



ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR 1965.

GUERNSEY :

1966.



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Report of the Medical Officer of Health for 1965

Lukis House,
Grange,
Guernsey.

17th August, 1966.

Sir,

I have the honour to present to you my Annual Report on the health of the Bailiwick of Guernsey for the year 1965.

I have the honour to be, Sir,

Your obedient servant,

A. T. G. THOMAS, M.D., B.S., D.P.H.,
Medical Officer of Health.

The President,
Board of Health,
Guernsey.

LIST OF CONTENTS

	Page
Introduction	3
General	5
Population:	
Births	7
Deaths	8
Comments on Causes of Death	8
Cremations	10
Infant Mortality	12
Marriages	12
Care of the Aged	12
Infectious Diseases	17
Cancer	19
Influenza Vaccination—Guernsey	21
Food Control	23
Health Legislation	23
Health Education	24
Water Supplies	24
Swimming Pools	25
Sewerage and Sewage Disposal	25
Beaches and Bays	26
Pharmacy, Poisons and Dangerous Drugs	28
Poisonous Substances	28
Rodent Control	28
Housing and Public Health	29
Health Visiting	30
Alderney—Report from Dr. D. C. Bell	32
Laboratory—Report from Chief Technologist	33
Report from Chief Public Health Inspector	34
Members of the Board of Health	45
Members of the Public Health Committee	45
Members of Staff	46

TABLES:

I Geographical—Meteorological Statistics	4
II Population—Births-Deaths	11
III Census, 1951—Census, 1961	16
IV V.D. Statistics	18
V Cancer Statistics	19
VI Annual Statistics for Health Visitors	31

APPENDICES:

I Population by Age Groups, 1931-1961	47
II Selected Guernsey Health Statistics	48
III Deaths by Age Groups and Causes	49
IV Vital Statistics—Comparison Guernsey/U.K.	62
V Public Health Department—Cost of Operation	63
VI School Medical Services—Annual Report for 1965	64

INTRODUCTION

The Administrative Background

The administrative area embraced by this Report includes Guernsey, Alderney, Herm, Sark, and Jethou. Communication is by air and sea to Alderney and by sea to the other Islands. To anyone unfamiliar with the Island who wishes to study the information contained in the Report it is perhaps helpful to note that the whole background differs in many respects from that of a conventional local authority on the mainland.

The Public Health Department functions under the Board of Health, which is one of the standing committees of the States of Guernsey and it derives its powers and responsibilities largely from local legislation. This means virtual independence from the mainland in the field of public health, though in practice valuable assistance is given in dealing with certain problems by the Ministry of Health and the Wessex Regional Hospital Board. Further, the Island is outside the scope of the National Health Service, though an arrangement exists on the one hand for the treatment of visitors and on the other for Island patients to receive treatment on the mainland for ailments for which suitable provision does not exist here.

Another interesting feature is that the static nature of the population makes epidemiological and environmental study of the people easier than in a mainland community, and this has in fact attracted one or two research workers in these fields. The population may be divided roughly into urban and rural communities and the main occupations are the growing of tomatoes and flowers, and commerce. Light industry is showing some promise of development, and of course the substantial number of summer visitors is a valuable economic factor.

TABLE I

GEOGRAPHICAL

The Island of Guernsey is seventy-five miles from Weymouth, forty-two from Cherbourg and sixty-one from St. Malo. Its area is 24.5 square miles and its highest point is 345 feet above sea level.

METEOROLOGICAL STATISTICS

SUNSHINE:

Total hours	...	...	...	1,694.1	Sunless days, 1965	...	...	...	63
Average, 50 years	...	...	...	1,875.5	Average, 50 years	...	...	...	58

Comparative Sunshine hours, 1965

Highest total hours in the British Isles:

1. Jersey (St. Helier)	...	...	...	1,885.4	4. Jersey (Gorey Castle)	...	...	...	1,805.8
2. Shanklin	...	...	...	1,883.4	5. Sandown	...	...	...	1,795.9
3. Ventnor	...	...	...	1,815.7	6. Dale Fort	...	...	...	1,783.5

RAINFALL:

Total inches, 1965	...	...	...	40.18	Rain days, 1965	...	...	...	186
Average, 50 years	...	...	...	35.77	Average, 50 years	...	...	...	186

TEMPERATURE:

							°C.	°F.
Yearly mean	...	...	...	...	...	...	9.9	49.9
Average, 50 years	...	...	...	...	...	...	10.7	51.3
Mean daily range	...	...	...	...	...	...	4.6	8.2
Average, 50 years	...	...	...	...	...	...	4.9	8.9

WIND:

	Calm	N.	NE.	E.	SE.	S.	SW.	W.	NW.
Days in the year	5	29	43	34	39	30	66	70	49

Force :

Monthly mean	...	...	3.9	Gales	...	...	...	15
Average, 120 years	...	...	2.9	Highest gust	...	...	...	77 m.p.h.

“Health is the most precious possession a man has.
Health and a good estate of body are above all gold.”

Ecclesiastes I, XXX, 15.

GENERAL

Various personnel changes took place during the year. In the sanitary inspectorate an advertisement for two additional inspectors produced a number of well-qualified and suitable candidates and of these Mr. Smith and Mr. Bairds (to be confirmed) were ultimately selected. This is an important move forward. Amongst other things it means that it will be possible for the routine district inspections to be carried out to deal with unsound housing, nuisances and the like, and much closer supervision will be possible in relation to food stores and catering establishments. Till now, the inspectorate has had its time fully occupied in dealing with specific complaints. This is not really satisfactory since the public have long been conditioned to accepting inferior standards of hygiene and are slow to complain to the department, save in bad cases. This augmentation of staff means that we can proceed with our plans to make the public aware of the social and health services available to them. This, of course, was not feasible with a restricted staff. A further administrative advance was the appointment of an unestablished shorthand/typist clerk to assist the Chief Public Health Inspector. This, with the attainment of an efficient filing system means that a start can be made towards the proper maintenance of records and some degree of sorting out of existing data. In circumstances where action to rectify sanitary defects is nearly always somewhat slow in implementation, adequate paper work is the more essential.

The work of the School Nurses/Health Visitors continued smoothly and more effectively with the arrival of Miss M. Thomson Brown to increase the numerical strength. On advertising for an additional Health Visitor we received no suitable applicants and a further advertisement was put out in October. If this vacancy can be filled, the establishment and strength of Health Visitors/School Nurses will be brought nearer to that generally accepted on the mainland.

The main objective of this service is the bringing of Health Visitors into the closest possible association with the families in their districts and to create a friendly atmosphere in which parents or anyone else in the home can discuss their problems with the utmost freedom.

Co-operation between the Health Visitors and District Nurses is continuing on the whole to be very good but much still remains to be done in co-ordinating the work of the two services so as to secure maximum efficiency. One proposal regarding this seems to offer considerable promise which is that the Public Health Department should establish a Child Welfare Centre of its own. The main problem confronting us here is that of accommodation. In its initial stages the clinic would certainly have to be run in some existing building with adequate heat and light and with parking space for prams and cars. It would also need to be reasonably centrally situated. Such premises are very hard to come by.

The particular importance of this project is that it could be demonstrated to nurses and public alike just how a modern Child Welfare Centre should be run. It follows, therefore, that a good standard should exist from the outset. The closer rapprochement between these two services is only one facet of the whole background of social services generally. It is quite evident that public health departments everywhere are playing a greater part in co-ordinating social services in relation to preventive medicine and there is much to be gained from such a policy. Insistence by various welfare organisations on isolating themselves from each other leads to uneconomic operation and overlapping. One possible remedy for this, which has proved successful in some instances, is the formation of a federation of social services, consisting of representatives of the more important ones which meets from time to time to discuss current problems both as regards policy and casework.

Perhaps there is no field of endeavour in which the need for greater co-operation exists than in the continuing problem of the care of the aged. This will be dealt with in greater detail later in the report but it must rank at present as one of urgency. The degree of care which can be given to severely handicapped elderly folk in their own homes falls very far short of what is desirable and efforts cannot be relaxed until we can feel that they receive reasonable care. If this can be done it will be a service not only to the old people but to their families. Granted that some of the younger generation are unco-operative in caring for their parents but there are others who suffer much hardship and detriment to their own family-life because of the needs of the elderly.

As regards other general health work carried out throughout the year, a continued study was made of the control of poisonous substances used in agriculture. This, together with a survey of the influenza vaccination campaign will be the subject of special studies in this report. Co-operation was maintained with the States Dairy in checking the supply of safe and clean milk to the population. Co-operation with the Water Board continued and the year produced no problems of any importance. The question of water supplies from wells was studied, in particular wells which supplied visitors staying in isolated dwellings. On our representation, and after consultation with the Tourist Committee, several of these dwellings were connected to the mains supply. This was a move in the right direction.

Early in the year the question of representation at the Annual Conference of the Royal Society of Health was discussed and a slight departure from the normal custom was agreed. Instead of attending the conference, the Assistant Medical Officer of Health and the Administrative Assistant to the Medical Officer of Health spent a few days in Bristol studying the workings of their highly developed Public Health Department. The principal reason for this was that we are endeavouring to overhaul our whole system of medical records at Lukis House with special reference to those dealing with inoculation and vaccination. This is a formidable task because many differing recording procedures had been used. Moreover, it was necessary that a system of records should be built up so that each member of the public could check his own vaccination state. Proper records are essential for the enforcement of compulsory immunisations against diphtheria and small-pox. The visit proved most helpful and much useful information was obtained.

A visit was made with the Sewage Disposal Co-ordinating Committee to study the sewage purification works in Jersey. This again was most useful.

In October, the Medical Officer of Health also visited Portsmouth to see a new type of sewage purification apparatus which utilised chlorine extracted from sea water. This proved most interesting and may ultimately be embodied in the Creux Mahie purification plan.

Several visits were paid to Herm, where the water supply, both quantitatively and qualitatively, caused some anxiety during the height of the season. Undertakings were given that improvements will be effected before next season.

Finally, one administrative change deserves mention and that is the formation of the Public Health Committee. This arose from the fact that, owing to the very heavy responsibility of hospital planning and management, the Board of Health found it difficult to give enough time to the problems of preventive, as opposed to clinical medicine. It was accordingly agreed to make a division between these two main responsibilities and to form an ad hoc Public Health Committee to deal with preventive and social medicine. This change promises well and is the more important since the whole principle of prevention is one in which our local concept has fallen behind trends on the mainland, and much work lies ahead in securing its full acceptance. The formation of the Public Health Committee, and the growth of the Department's staff, which is in process of increasing from seventeen to twenty-five, together with the progress of a scheme to reorganise records, prompted a review of office accommodation. This emphasised the fact, long appreciated, that the present amenities at Lukis House fall far short of modern standards in efficiency, economy and public image. Proposals for improvement were put forward for consideration, but no decision reached during the year.

Once again, I would like to acknowledge the help and co-operation given to the department by the Board of Health, the Education Council and their Officers, and other States Departments, and to commend the diligent work of the staff.

POPULATION

The 1965 estimates are as follows:—

Guernsey	...	...	...	...	45,611
Alderney	...	...	...	...	1,472
Sark	...	...	...	...	560

As regards visiting population, the registered accommodation available for tourists in 1965 totalled 11,988 beds. There were 129,209 arrivals by air and 64,835 by sea, making a total of 194,044.

Births

In the year 1965 there were 816 live births registered in the Island. Of these 427 were males, and 389 females. The Birth Rate is therefore 17.9 per thousand. The corresponding rate for 1964 was 19.6. The rates of illegitimate births in relation to 1,000 live births in urban and rural areas of England in 1964 were 79 and 46 respectively; and for the country as a whole 72. Guernsey's rate was 78, i.e., 1:13.4 live births.

There were 11 stillbirths as against 7 in 1964 giving a rate of 13.48 per thousand live births.

Deaths

There were 568 deaths in 1965, 28 more than in 1964. This gives a crude death rate of 12.45 per thousand and a corrected death rate of 10.71 per thousand. The correction is related to the particular age and sex distribution of the population in Guernsey and the Comparability Factor is 0.86.

Comments on Causes of Death

1. General

This year showed some deviation from the normal pattern of mortality inasmuch as the total number of deaths increased from 540 to 568. There is no particular group of causes to account for this, save in diseases of the respiratory system which were 61 as compared with 39 in 1964. There is no reason to suppose that the increase in deaths was due to any extraneous or "imported" factor. The trend will probably continue until the process of ageing of the population diminishes and stabilises, as it must do at some time.

2. Pulmonary Tuberculosis

Deaths from this disease constituted a new low record being two, as against four last year, both in the 45-64 age-group. This progress towards the elimination of the disease is the more satisfactory when it is appreciated to what extent its occurrence is favoured by poor environmental conditions, overcrowding, dampness and poor housing and a sub optimum diet, although there is slow progress in remedy of all these conditions. Nevertheless, two points must not be ignored; these are the continuing possibility of the importation of infection by visitors and imported labour, and the fact that "herd" immunity decreases as infectious foci are removed. Our safeguards are contact tracing and B.C.G. vaccination.

3. Cancer

As usual, cancer of the lung and respiratory passages is dealt with separately. Taking the usual commonest sites, cancer of the stomach caused 20 deaths as compared with 15 in 1964 and 16 in 1963. The total deaths from cancer were, however, 104 as compared with 100 in 1964. Deaths from cancer of the large intestine were 10 as against 9 in 1964. As in many previous years, the figures show their usual close resemblance from year to year, and the overall total varies little. Perhaps some slight reassurance might be derived from this but the problem needs to be related to the picture as a whole. While the cancer figures do not show any dramatic increase, there are several other aspects which must be considered.

Cancer Deaths

Year					Year				
Deaths					Deaths				
1946	...	...	...	78	1956	...	...	68	
1947	...	...	...	66	1957	...	...	104	
1948	...	...	...	77	1958	...	...	102	
1949	...	...	...	88	1959	...	...	97	
1950	...	...	...	62	1960	...	...	100	
1951	...	...	...	98	1961	...	...	98	
1952	...	...	...	91	1962	...	...	114	
1953	...	...	...	70	1963	...	...	100	
1954	...	...	...	78	1964	...	...	100	
1955	...	...	...	81	1965	...	...	104	

The first factor is that, while deaths from nearly every other cause (save circulatory diseases) have diminished, this trend is not shared by cancer deaths. In other words, prevention and treatment seem to be succeeding in most fields other than this. The other factor is that since the apparent rate of cancer rises in an ageing population, and the population continues its trend to longevity, so the need for enhanced measures against it becomes more urgent. Attention to teeth and diet can do something to help.

4. *Coronary Thrombosis*

In 1965, 201 deaths were attributed to circulatory diseases generally, compared with 188 in 1964 and 183 in 1963. Of these, coronary thrombosis accounted for 109 deaths, against 91 in 1964 and 95 in 1963. These figures mount steadily and inexorably. Allowing for the ageing of the population, what factors are at work in our changing environment to account for this?

Deaths from Circulatory Diseases

<i>Year</i>					<i>Deaths</i>	<i>Year</i>					<i>Deaths</i>
1946	...	...	...	...	111	1956	...	...	...	...	174
1947	...	...	...	...	111	1957	...	...	...	...	173
1948	...	...	...	...	98	1958	...	...	...	...	192
1949	...	...	...	...	141	1959	...	...	...	...	191
1950	...	...	...	...	190	1960	...	...	...	...	183
1951	...	...	...	...	174	1961	...	...	...	...	133
1952	...	...	...	...	156	1962	...	...	...	...	187
1953	...	...	...	...	136	1963	...	...	...	...	183
1954	...	...	...	...	190	1964	...	...	...	...	188
1955	...	..	...	...	138	1965	...	...	...	...	201

To what extent do stress, tension and worry contribute to this increase? What other environmental influences are at work? Possibly one of the biggest changes in environment on the mainland has been the advent of the “Welfare State” but the impact of this in Guernsey is extremely small. One thing which seems evident is that most of our inhabitants are not protected against worry, depending as they do on agriculture and tourism—both of which have their uncertainties. Whatever the answer may be there seems to be at present no “pointer” to any preventive measures which might be used in an attempt to reduce mortality from circulatory diseases.

5. *Bronchitis*

Thirteen deaths were returned as due to various forms of bronchitis, precisely the same number as in 1964; but these figures are not really very illuminating. It would really be better to take the total deaths attributed to inflammatory conditions of the lungs, i.e. 61, and to compare them with the 1964 figure of 39. This is quite a significant difference; but there are probably no other groups of diseases so much influenced in their incidence and severity by the impact of adverse weather conditions and the year, with its 200 hours shortfall of sunshine, was not one of our best. The impression is that we still compare very well with the mainland.

6. *Senility*

In 1965, 47 deaths were reported in which the major cause was senility, compared with 46 in 1964 and 50 in 1963. This is probably a conservative figure, as are the previous ones. There is unfortunately no preventive angle on this as yet, though a geriatric rehabilitation unit will help one day.

7. *Accidental Deaths*

In 1965 these totalled 21 compared with 17 in 1964. Only one picture stands out—five cases of drowning against three in the previous year. How many of these were preventable? Out of 568 deaths five does not sound many, but they are five too many just the same. Is everything being done to safeguard life around our shores?

Cremations

<i>Year</i>						<i>Total</i>
1955	...	..	...	...	...	55
1956	...	...	...	...	...	70
1957	...	...	...	...	...	69
1958	...	...	...	...	...	50
1959	...	...	...	...	...	65
1960	...	...	...	...	...	73
1961	...	...	...	...	...	80
1962	...	...	...	...	...	99
1963	...	...	...	...	...	106
1964	...	...	...	...	...	102
1965	...	...	...	...	...	122

Disposal of the dead by this method reached a new high level in 1965 when 122 cremations took place, an increase of 20 over 1964. This indicates a steady but slow increase over 50 in 1958. There is no doubt that cremation is a most desirable institution in this Island where every bit of agricultural land is needed and it is not a satisfactory situation when, in 1965, 446 earth burials took place as compared with 122 cremations. This has not been overlooked by the Board of Administration and it is gratifying to know that several progressive steps are contemplated. The first is a complete reconditioning of the cremation unit, which has given many years of service. This may lead to more economical functioning and will certainly give greater efficiency in terms of time. Secondly, a review of costs generally so as to provide a still greater inducement financially to relatives to accept cremation for their deceased. This should be accompanied if possible by more encouragement in providing the public with more information as to the increasing acceptance of cremation in Europe and its other favourable aspects. It is noteworthy that very few demands for cremation come from country districts as compared with urban areas, partly because of natural rural conservatism, but partly also from lack of information. No doubt the effect of all this will be reflected in our figures for 1966.

TABLE II *

YEAR	Estimated Population to middle of each year	BIRTHS		DEATHS			DEATHS Under 1 year	
		No.	Rate per 1,000	No.	Crude rate per 1,000	Adjusted rate per 1,000	No.	Rate per 1,000 Births
1946	38,038	872	22.9	431	11.3	7.9	35	40.1
1947	40,674	900	22.2	419	10.3	7.2	30	33.3
1948	43,179	870	20.2	445	10.4	7.3	17	19.5
1949	44,374	795	17.9	495	11.1	7.7	20	25.1
1950	44,792	746	16.6	480	10.7	7.4	22	29.5
1951	44,498	775	17.4	510	11.4	8.0	11	14.2
1952	43,367	736	16.9	464	10.7	7.5	24	32.6
1953	44,158	727	16.5	456	10.4	7.3	23	31.6
1954	43,414	689	15.8	492	11.3	7.9	9	13.1
1955	42,073	667	15.9	423	10.0	7.0	18	26.9
1956	41,149	701	17.0	495	12.0	8.4	14	19.9
1957	40,721	725	17.8	517	12.7	8.89	24	33.0
1958	43,450	717	16.5	497	11.4	7.98	16	22.3
1959	43,950	709	16.1	498	11.3	7.91	14	19.7
1960	44,700	769	17.2	491	10.9	7.63	11	14.3
1961	45,000	757	16.8	569	12.6	8.82	16	21.1
1962	45,203	797	17.6	569	12.5	8.68	15	17.6
1963	45,339	842	18.5	542	11.7	8.21	24	28.5
1964	45,475	891	19.6	540	11.89	10.22	19	21.32
1965	45,611	816	17.9	568	12.45	10.71	16	19.61

* TABLE II—Note (a) Methods of estimating the mid-year population were changed in 1958 and 1964 in an effort to achieve greater accuracy.

Note (b) Estimates for 1963 and 1964 are based upon preliminary population figures compiled from the 1961 Census Returns.

Infant Mortality

The number of deaths under one year of age was 16 giving an Infant Mortality Rate of 19.61. The rate for 1964 was 21.32 and for 1963 was 28.5 per thousand live births. There were 11 deaths under one month giving a neo-natal death rate of 13.48 per thousand live births. The rates for England and Wales in 1964 were: Infant Mortality—19.9, Neo-natal—13.8.

Marriages

Three hundred and sixty-two marriages took place during the year as against 329 in the previous year. The corresponding rates are 7.94 and 7.23 per thousand head of population.

THE CARE OF THE AGED

The task of endeavouring to care for elderly persons begun in January, 1964, continued through 1965. Comparative figures are as follows:

	1964	1965
Total Waiting List at 1st January	116 (32 M. 84 F.)	95 (32 M. 63 F.)
Deaths during year	50	45
Admissions to Institutions during year	47	66
Total Waiting List at 31st December	95 (32 M. 63 F.)	106 (47 M. 59 F.)

It will be seen that there is little change in the overall situation.

Factors which operate in controlling the size of the problem are as follows:—

- (1) Increase in longevity.
- (2) The number of persons who die without going on to the waiting list.
- (3) The number of persons who die while awaiting admission to an institution.
- (4) The number admitted to institutions during the year.
- (5) The number who die in institutions.

Once again it seems evident that the mere multiplication of beds in institutions for sick and aged persons is only part of the answer, although the present shortage of other and more economical ways of dealing with these cases causes a tendency in this direction, and a certain increase in this type of accommodation, at any rate until the whole matter can be sorted out, is inevitable. The lack of it during the year has given rise to much hardship and suffering not only to the patients themselves but to their relations and friends. Their domiciliary care also occupies a good deal of time of the District Nurses and Health Visitors, possibly to the detriment of their duties to younger people.

It cannot be too strongly emphasized that, in studying the problem of the aged, the individual patient is by no means the only person whose welfare and happiness is at stake. In fact, he or she is often the centre of a circle of personal impacts. These include relatives, voluntary services and doctors, and many of the doctors give up hours of unpaid service to patients they have known for many years and who have now become unable to pay for their services. As regards relatives, some undoubtedly evade their obligations, but there are many, some of them ageing and distressed themselves, who show great unselfishness

and devotion. It follows, therefore, that the removal of a suitable case from his home to hospital can bring relief, not only to the patient, but sometimes to a large circle around him. Further, their adult sons and daughters can give more attention to their own children if relieved of the responsibility for the care of the aged.

Some twenty beds are still awaited at St. Peter Port Hospital and a further twelve or so are held up pending the conversion of the Kinnersley Ward at the Sanatorium.

What are our future plans? Accepting the fact that all deterioration caused by age is a gradual and cumulative process, provision must be made for the various stages at which assistance is needed.

Home Care

- (i) Comment has been previously made on the difficulty encountered here. The basis of domiciliary service must depend upon visits to the house by properly trained lay workers or capable domestic staff. In other words, "Home Helps". Owing to the competition of agriculture, industry and commerce, these are extremely difficult to obtain. There is also the fact that such work is not attractive. Visits by a Health Visitor or District Nurse can help but are limited. Organised voluntary services (Meals on wheels) are valuable and the kindly relative sometimes helps. A system of laundry collection, cleansing and delivery has been suggested and could give valuable service. It has not proved practicable because the St. Peter Port Hospital laundry cannot cope with it.

Towards the end of the year trials were being given to a system whereby hospital type beds with cot sides and impermeable mattresses were supplied on loan, and this helps in cases where people are incontinent and tend to wander at night. Voluntary youth organisations play a part and so do the Women's Institutes. Some of these services help to relieve one of the greatest hardships of the elderly which is loneliness but there is still more that needs doing. A proposal has been made to a voluntary organisation that the provision of telephones at a very low cost might help the infirm, partly by maintaining contact with friends and partly in the event of medical emergency. This is being investigated. Another possibility is the provision of an external warning light which could be switched on to summon help in the case of people who live alone and may be taken suddenly ill.

- (ii) *The Role of the Health Visitor and District Nurse*

Since home helps are very difficult to obtain, an important part must be played in home care by the Health Visitor and District Nurse. Unfortunately, amongst both doctors and the public some misunderstanding exists as to their respective roles. The District Nurse's functions are primarily nursing from the practical side and the day to day treatment of sickness prescribed by the doctor and the general hygiene of the patient is her responsibility. As regards the Health Visitor, her duties are considerably wider. She deals with social services available, such as Meals-on-Wheels, the provision of equipment such as special beds, and she reports on the sanitary circumstances of the dwelling for attention by the sanitary inspectors. She is required to assist in the maintenance of an up-to-date priority register, so that beds which become vacant are used to their

greatest usefulness. She is concerned with safety in the home and in encouraging reasonable attention to the patients by their relatives. In fact, she is concerned with every aspect of the patient's welfare and environment other than clinical nursing service.

It cannot be too strongly stressed that it is in the interests of both the States and the individual that much attention should be given to domiciliary care which, if adequate, can delay admission to expensive institutions, can ease the burden on relatives, and delay the removal of elderly folk from their cherished home environment. Efficient though institutions can be, they can never quite compensate for the loss of a home and they carry a depressing suggestion of "the last stage".

Care Outside the Home

The Rehabilitation Unit

The problem of the care of the aged has naturally attracted the attention of local authorities all over England, especially over the last ten years. Some have achieved remarkable progress, others are probably less well advanced than we are in Guernsey. Naturally, the Ministry of Health has concerned itself in co-ordinating effort and offering advice and experience as to the best lines upon which any authority can tackle its problems. Local circumstances influence this, but it is generally accepted that the best results can be achieved by establishing a "rehabilitation unit". This has a number of important functions:—

- (a) to examine and treat persons of advancing years for minor ailments and to prevent deterioration;
- (b) to provide short-stay accommodation for such treatment, medical or surgical if necessary;
- (c) to provide a centre for a physician specially qualified to deal with ailments of the aged;
- (d) to maintain a register of cases in relation to their suitability for admission to institutions;
- (e) as a centre for the reference of patients in need of specialised services to the appropriate departments of hospitals.

Such a centre should be situated either close to or as part of a general hospital. The importance of this type of unit as the administrative hub of geriatric service cannot be overstressed. On the one hand it prolongs the ability of the patient to live independently in his own environment, and on the other, it prevents the occupancy of beds in institutes by cases which do not properly need such care at their particular stage of senescence. Unfortunately, in some districts, as in our own, it has not been possible yet to provide such a unit and this is one of the reasons why the present shortage of institutional beds exists. Once it is established, the situation can gradually be brought into order.

Welfare Type Accommodation

This type of accommodation represents a middle grade between domiciliary care and "hospital type" accommodation. It envisages institutions where qualified nursing is not a prominent feature although it is desirable to have at least one qualified person on the staff. Basically its purpose is to provide dwelling accommodation for persons who, owing to a deterioration in their own housing,

or for other domestic reasons, or owing to somewhat increased infirmity, cannot be looked after at home but are not suitable for hospitalisation. These people should be reasonably ambulant and capable of looking after themselves with perhaps a little occasional help. If such institutions are well designed (though of course it is often impossible to achieve this), one outstanding hardship of the aged can be modified. This, of course, is the problem of loneliness. The patients should have their own bed-sitting rooms while communal feeding and day accommodation provide company for those who desire it. Such accommodation is available in the Island in, for example, old people's homes such as Longue Rue House and the Hostel of St. John. Neither of these is at present under the control of the Board and neither participates in a planned geriatric scheme. "Welfare type" accommodation is a very important factor in coping with the problem of geriatric care. Its especial advantages are:

- (i) it is less expensive to occupy or construct than hospital type buildings;
- (ii) it has a greater appeal to the patients;
- (iii) it is more economical to run since only a nucleus of trained staff is needed.

If proper use is to be made of it *all* people installed in it should be selected from the geriatrics register, and pass through the Rehabilitation Centre when it becomes available. This is essential since proper geriatric assessment is a matter of medical opinion.

"Hospital" Accommodation

15

This is the third stage. Such accommodation should be largely reserved for patients whose degree of disease or infirmity renders them virtually bedridden. It is very important that patients should not enter this accommodation before it becomes entirely necessary. If they do, it is bad for them and an uneconomic proposition generally. Even with this type of patient cases of unexpected improvement can occasionally occur and there should be some flexibility in outlook so that they might be returned, at any rate for a period, to their previous environment. Further, a section of such accommodation might be utilised on a temporary basis for other types of patients such as:—

- (a) persons temporarily removed from their homes to give a respite to those caring for them on the strict understanding that they are received back; and
- (b) elderly persons who become actually ill but who have a reasonable prospect of being discharged when they recover. At present this type of patient constitutes a severe embarrassment to the Princess Elizabeth Hospital but they are nevertheless in urgent need of hospital treatment. Hospital type accommodation at present available is in Les Côtis Hospital Home and the St. Peter Port Hospital, both of which, of course, have substantial waiting lists.

Private Homes

These are really a form of "welfare" accommodation and are, in fact, either small institutions such as Le Platon Home or accommodation provided by people who are willing to accept elderly people at a fee. Assistance can sometimes be given in this by the States Insurance Authority. In a good many cases arrangements of this kind have worked quite well but the cost is usually quite substantial (of the order of £10.0.0. per week) and there is a limit to the

amount of attention they can reasonably be expected to be given by the average landlady. Le Platon Home is under private control and does not come under the general scheme for admission of suitable cases.

Conclusion

It can be said that we are making definite, though slow progress in coping with the geriatric problem in the Island. The provision of more beds at the Sanatorium and St. Peter Port Hospital will help considerably and so will the advent of the geriatric unit proposed at the Princess Elizabeth Hospital. One of the essentials of geriatric care on a practical basis is the operation of an efficient assessment scheme for seeing that the right cases find their way into the right places at the right time. The proposed geriatric unit will be a centre for this and it is hoped that when it begins to function all institutions catering for the needs of the aged may see the benefit of co-operating with a central authority instead of continuing in the present pattern of fragmentation.

TABLE III

Census 1951

Ages—(Five Year Groups)

<i>Age last Birthday</i>					<i>Guernsey including Herm & Jethou</i>		
					<i>Persons</i>	<i>Males</i>	<i>Females</i>
65-69	...	...	...	...	1,831	816	1,015
70-74	...	...	...	...	1,517	660	857
75-79	...	...	...	...	1,016	430	586
80-84	...	...	...	...	567	207	360
85-89	...	...	...	...	248	84	164
90-94	...	...	...	...	47	17	30
95 and over	...	...	...	...	11	1	10
Aged 65+					5,237	2,215	3,022

Census 1961

Ages—(Five Year Groups)

<i>Age last Birthday</i>					<i>Guernsey including Herm & Jethou</i>		
					<i>Persons</i>	<i>Males</i>	<i>Females</i>
65-69	...	...	...	...	2,099	873	1,226
70-74	...	...	...	...	1,649	646	1,003
75-79	...	...	...	...	1,229	468	761
80-84	...	...	...	...	749	284	465
85-89	...	...	...	...	346	119	227
90-94	...	...	...	...	86	22	64
95 and over	...	...	...	...	14	2	12
Aged 65+					6,172	2,414	3,758

INFECTIOUS DISEASES

King Edward VII Sanatorium—

Patients Admitted during 1965

<i>Diseases</i>	<i>Cases</i>	<i>Deaths</i>
Tuberculosis and epilepsy	1	—
Tuberculosis and leukaemia	1	—
Lupus of face	1	—
Scarlet fever	1	—
Dysentery	2	—
Reiters Syndrome	1	—
Whooping cough	2	—
Measles	4	—
Measles and bronchopneumonia	2	—
Measles and convulsions	1	—
Erysipelas and congestive heart failure	1	1
Chicken pox and multiple sclerosis	1	—
P.U.O.	1	—
Pulmonary Tuberculosis	19	2

Admissions totalled 38, two more than in 1964. In addition, 7 geriatric cases were admitted. This number corresponds roughly to the average number of vacancies which may be expected in this section of the sanatorium in one year.

Tuberculosis

Twenty-one cases were admitted to the Sanatorium with two deaths, as against eleven in 1964 with two deaths. This gives an attack rate of 0.46 and a death rate of 0.044 per thousand of the population. This is quite satisfactory having regard to the fact that the usual type of case which presents itself nowadays is very rarely one of new infection but rather one where other complications either caused by, or associated with an old infection are prominent. These are bronchitis, emphysema, pulmonary fibrosis and various forms of cardiac impairment. What in fact has happened is that the prevalence of pulmonary tuberculosis twenty years ago has left a legacy of “respiratory cripples” and this type of case will, in the natural course of things, disappear in time. Reference has been made in previous reports to the difficulty of finding light work for these patients when they proceed to out-patient care. Next year it is contemplated that a few of them might be employed as “beach wardens” on our busier beaches. Provided with some form of badge, they might help to discourage and deal with litter and give some attention to the general preservation of the amenities. Such employment would be beneficial to their health, and give them some sense of usefulness.

Tuberculin Testing and B.C.G. Vaccination

During the year 1,304 young persons and adults were tested, and 453 school children protected by B.C.G. This compares with 445 children protected in 1964.

TABLE IV
VENEREAL DISEASE

	<i>Male Section</i>		<i>Female Section</i>	
	1964	1965	1964	1965
1. Number of persons under treatment or surveillance on 1st January:				
Syphilis	11	7	4	5
Gonorrhea	8	29	1	0
Non-specific or non-venereal conditions	5	24	0	0
2. Number of persons previously removed from register who returned for treatment due to re-infection ...	0	0	0	0
3. Number of fresh infections during the year:				
Syphilis contracted locally ...	2	0	1	1
Syphilis contracted outside the Island	1	2	0	0
Gonorrhea contracted locally ...	11	8	4	10
Gonorrhea contracted outside the Island	18	24	0	0
Non-specific or non-venereal conditions contracted locally	15	13	1	15
Non-specific or non-venereal conditions contracted outside the Island	1	31	0	0
4. Cases discharged:				
Syphilis	6	7	0	0
Gonorrhea	4	55	5	10
Non-specific or non-venereal conditions	4	64	1	15
5. Number of persons remaining under treatment or observation on 31st December:				
Syphilis	7	2	5	6
Gonorrhea	29	6	0	0
Non-specific or non-venereal conditions	24	4	0	0
6. Number of attendances	492	618	79	56

Poliomyelitis

As we have rather come to expect, this disease was entirely absent during 1965 and this happy state of affairs is likely to continue provided that we maintain a steady system of protection. During the year there were 1,823 inoculations by Island Doctors and 1,580 by the Public Health Department. This compares with 1,361 and 601 respectively in 1964.

Diphtheria

Much the same can be said of this disease as of poliomyelitis, though with the slight difference that, since protection against it is legally compulsory, there is no risk of a falling off of our group immunity owing to neglect of inoculation. The advent of multiple vaccination agents is another insurance against this.

Measles

Seven cases of this disease were admitted to the Sanatorium in 1965. This compares with two in 1964. This is not a very significant increase but measles is still not a condition which can be too lightly regarded. Towards the end of the year the Ministry of Health announced the production of a measles vaccine, but said that at present no large scale campaign involving its use was contemplated. Developments are awaited with interest.

Enteritis

It is interesting to observe that only two cases of intestinal infection were admitted to the Sanatorium during 1965 and one in 1964. This cannot truly reflect the frequency of the occurrence of this type of disease in the Island. Rather, in fact, does it suggest that it is so frequently found, usually in mild character, that it is very seldom regarded as needing hospital treatment. In the end little harm seems to be done; but the warning must be repeated that if relatively trivial infections can reach the intestinal tract of a large number of people with apparent ease and frequency, so also could the more virulent types if they gained access to the island. This would produce a very different picture.

Cancer

TABLE V
Guernsey

Year							Cancer All Forms	Cancer of Lung
1954	...	...	...	...	...	...	78	9
1955	...	...	...	...	...	...	81	18
1956	...	...	...	...	...	...	68	11
1957	...	...	...	...	...	...	104	19
1958	...	...	...	...	...	...	102	25
1959	...	...	...	...	...	...	97	21
1960	...	...	...	...	...	...	100	16
1961	...	...	...	...	...	...	98	14
1962	...	...	...	...	...	...	114	28
1963	...	...	...	...	...	...	100	28
1964	...	...	...	...	...	...	100	19
1965	...	...	...	...	...	...	104	22

		Cancer all Forms		Cancer of Lung		Cancer of Lung per 1,000 of population	
Year		Jersey	Guernsey	Jersey	Guernsey	Jersey	Guernsey
1964	.....	157	100	40	19	0.65	0.42
1965	.....	161	104	56	22	0.9	0.48

Cancer of the Lung and Respiratory Passages

The total deaths from cancer of the lung during 1965 were twenty-two. This is three above the average (19.1) over the past twelve years, and the whole picture deserves some thought. First of all, of course, it is a statistical commonplace that inferences drawn from a relatively small population sample can be misleading—but this applies to actual incidence and ratios to the population and not to year-to-year trends. What, in fact, are the other influences at work,

apart from cigarette smoking, which might influence our figures? One is the slight increase in deaths from cancer of all forms coincident with the gradual ageing of the population and another is the possible diminution in smoking in response to propaganda. This latter, however, would be likely to occur more in the youthful section of the community. For comparison let us take the annual increase in lung cancer deaths on the mainland over the past ten years.

*Deaths from Malignant Neoplasm
of Trachea, Bronchus and Lung
(England and Wales)*

				<i>Males</i>	<i>Females</i>
1955	...	...	...	14,761	2,438
1956	...	...	...	15,544	2,553
1957	...	...	...	16,358	2,670
1958	...	...	...	17,040	2,780
1959	...	...	...	18,181	2,882
1960	...	...	...	18,882	3,118
1961	...	...	...	19,460	3,350
1962	...	...	...	20,278	3,501
1963	...	...	..	20,757	3,677
1964	...	...	...	21,476	3,895
1965	...	...	...	n.a.	n.a.
Total	...	...	...	182,737	30,864

TOTAL: 1955 - 1964 213,601

If we apply these figures to our population we should have had 204 deaths over the same period. In fact we had 215.

Smog and diesel fumes, as well as tobacco smoke, have been blamed for causing lung cancer. Certainly we escape these largely here. Possibly there are other factors undiscovered as yet. At any rate, the fact that our figures are only three worse than our twelve-year average should not in any way encourage any let-up in effort to discourage the *starting* of smoking by young folk.

Influenza: Vaccination

For several years past, interest has been shown in the possibility of protecting the public, or at any rate those who are susceptible to influenza and "colds", against the inconvenience of these ailments, which also have their impact on commerce and social life. The results have been somewhat inconclusive and it was felt desirable to make an investigation to see whether:

- (a) the results justified more vigorous work in this field;
- (b) they showed that, at this stage, it was not worthwhile to undertake this.

Such an investigation was undertaken by Dr. White and it is worthwhile giving it in some detail so that we may know how we stand.

Influenza Vaccination—Guernsey

Winter 1964 - 1965

An analysis of replies received from vaccinated volunteers in response to a 3-part questionnaire.

By Dr. C. G. White — Assistant Medical Officer of Health.

The following questionnaire was sent to all persons who had volunteered for vaccination against influenza during the early winter of 1964-65.

- (1) Did you have any reaction following vaccination? If so, what?
- (2) Do you usually suffer from influenza or recurrent colds during the winter?
- (3) Do you feel that you have suffered less during the past winter season?

192 replies were received to this questionnaire and these replies are broken down numerically at TABLE A.

TABLE A	Usually suffer frequent colds or influenza in winter	Usually free of colds or influenza in winter	Considered that 'flu vaccination was beneficial 1964 - 1965	Considered NO benefit from 'flu vaccination
Total persons vaccinated who replied 192	92 (48%)	100 (52%)	113 (59%)	79 (41%)
Persons who had no reaction to vaccination .. 150	76 (51%)	74 (49%)	93 (62%)	57 (38%)
Persons who experienced slight reaction to vaccination.. .. 21	10 (48%)	11 (52%)	11 (52%)	10 (48%)
Persons who experienced severe reaction to vaccination .. 21	6 (29%)	15 (71%)	9 (43%)	12 (57%)
Total of persons who experienced any reaction .. 42	16 (38%)	26 (62%)	20 (48%)	22 (52%)

NOTE: Percentages are expressed to nearest whole number.

It will be observed that of all persons replying to the questionnaire, whether or not they had experienced any reaction to the vaccination, 59% considered that they had derived benefit from vaccination. Of those who claimed no reaction at all, 62% considered that they had benefited from vaccination.

Of all those who experienced some reaction (42), exactly half (21) were considered to have had a severe reaction and half a slight reaction. Of all those who reacted, 48% believed that the vaccination had done them some good, while of those who were considered to have had a severe reaction, only 43% claimed any benefit.

Of 113 persons who claimed to have benefited, 13 stated that they had had a cold and influenza-free winter, while of those who found no advantage from vaccination, 8 had attributed persistent colds or sinusitis to the fact that they had been vaccinated.

One person who suffered a reaction to vaccination developed a small abscess at the injection site, which probably ought not to be attributed to the vaccine. This person usually suffered from colds or influenza each winter and considered that he had received benefit from the vaccine.

Of the 21 persons who experienced slight reactions, 2 had modified influenza-like symptoms some six to eight weeks after the injection. It is possible that these ought not to be attributed to the vaccine itself. The commonest slight reaction was an immediate cold, lasting anything from 7 to 14 days (7 persons) and stiffness or aching of the limbs (7 persons), while 5 persons complained of tiredness, loss of energy or "feeling run down" for several days after injection.

Of those who experienced reactions classified as severe (21 persons) 14 suffered a heavy cold or an actual influenzal attack within two weeks of the injection, while 5 persons suffered recurrent colds throughout the winter and one stated that he had "suffered with sinus" ever since injection. Of these six, four were people who did not normally suffer from recurrent colds during the winter.

Among those who believed that they had gained by vaccination several were most enthusiastic and claimed that, although in almost daily contact with persons suffering from colds and influenza throughout the winter, they had remained free from either during the whole season.

COMMENT: The figures are far too close to the law of averages (from which one would expect 50% to claim benefit and 50% to claim none) to warrant any enthusiasm for influenza vaccination. Undoubtedly, some people do benefit greatly, but they do not outweigh the fact that quite a number of others were clearly much the worse off for having volunteered, some throughout the whole of the winter after their injection.

Influenza vaccination should be offered without any compulsion or persuasion whatever. Some people will volunteer enthusiastically, as a result of previous dramatic improvement from earlier experience, but no-one should be coerced into the possibility of prolonged influenza-like symptoms.

The advantages are but very little better than might be expected from a control injection of sterile water and so far as employers are concerned (for example, the Civil Service Board), insufficient grounds exist to justify recommending influenza vaccination to employees as a measure likely to make any significant reduction in winter sickness absence.

STATISTICAL NOTE: The difference between the expected proportion who would claim benefit if the injection were worthless, and the actual population who did claim benefit is $59 - 50 = 9\%$. In a population of this size (i.e. 192),

this could have occurred by chance and is therefore not significant. For the injection to be considered as significantly valuable, 60.4% of 192 persons would have had to claim benefit, i.e. 116 persons. In fact only 113 persons claimed benefit from this vaccination thus the effect of the injection cannot be claimed to have been significant.

The general conclusion is that in the present state of our knowledge and the doubtful value of the vaccine, large-scale vaccination procedures are not indicated.

FOOD CONTROL

Staff difficulties again hampered our work to some extent in this field but it could be said that, in spite of difficulties, reasonable control was maintained. As in so many fields of activity and endeavour in public health work, there is a certain cumulative effect. Once catering and food handling establishments find that the conduct of their business is a matter of interest and sometimes of advice and admonition from official sources, they often make a move towards improving their standards. They are simply reminded that keeping up-to-date in a competitive market pays dividends. Further, slow though the public are to learn to expect and demand better service, there is also a gradual move in that direction. Finally, and this helps too, the number of newly opened food premises which are obviously right up to date also helps to raise the standard. In this matter, incidentally, it is hoped next year that arrangements will be made for *all* plans for new food handling and catering establishments to pass through the Public Health Department so that errors or omissions may be checked at the planning stage. This takes on an increasing importance as time goes by. A present and growing problem in the catering trade is that of staff, who have to be recruited from lower levels in the industrial scale and who, because of general full employment, are very intolerant of any kind of discipline. The logical consequence of this is a move to self-service and a streamlining of planning and equipment in the kitchen. The easier it is to keep a place clean the cleaner it is likely to be kept.

23

HEALTH LEGISLATION

As in previous years, it is regrettably not possible to report much progress in the field of major health legislation, particularly as regards food control and overcrowded premises. The fact is that no community remains static in regard to its various environmental problems. It is a commonplace that nearly all local authorities suffer a steady outgrowth of their housing, sewerage systems and water supplies. So also do their byelaws and other powers become outmoded. Superficially the law is a remote and impersonal thing, but it is meant to control and order the conduct of living people and as time goes by their needs, habits and outlook all change. If laws are to be effective, so they, too, must change. Speaking strictly from the public health point of view, what is really needed is a revision of the *Loi Relative à la Santé Publique*, 1934, and, in fact, much of the other legislation on public health matters as well. It is indeed difficult to see how or when this could be achieved.

HEALTH EDUCATION

A move forward in this field was the construction of six poster frames and their installation at strategic points in the town. These are made in permanent materials, a solid box type frame, with lock and key and a glass front. The principle is that posters are shown for some weeks and then changed. Accepting the fact that the impact of posters on the public is limited, it seems worthwhile nevertheless to exhibit a limited number of good ones where they are likely to be seen by many people who are waiting around for some purpose. The whole matter of health education in the Island is something of a problem as regards the public at large. Some ground is certainly covered by the Health Visitors—some in the schools—but this covers only a section of the community. Channels such as radio and television are the really important media, and so far they are virtually undeveloped. The Press is helpful but a little limited in scope and the public, not having had their interest aroused, tend naturally to be apathetic unless some “scare” comes along. When this does happen, public support for vaccination and other protective measures is certainly good, but it is a pity that we need to depend on alarm to provoke public interest.

WATER SUPPLIES

24 The year 1965 was uneventful as far as any problems connected with our water supply were concerned. Quantitatively it was adequate, save in a few instances of occasional short periods of individual low pressure. Considering the heavy influx of visitors during the summer months, and the fact that we depend so much on rainfall, we have much to be thankful for, bearing in mind that many local authorities in England are suffering grave anxiety about their supplies, especially in areas of rapid growth. Short of any dramatic climatic change, or rise in population, our satisfactory situation appears likely to continue.

Qualitatively, much the same can be said. Since much building has been in progress over the year, certain disturbances of the reticulation system were inevitable, and these are often accompanied by local temporary turbidity. The general level of tests taken from the mains supplies was high, however, and no instance occurred where any illness could possibly be associated with it. One aspect of our supply which had been causing slight anxiety for some time was the possibility that, in view of the wide use of poisonous and persistent agricultural chemicals in the Island, some traces of these might find their way into the reservoir or douits supplying it. Preliminary tests, however, showed the following results:—

<i>Sample Nos.</i>						<i>B.H.C. (Lindane)</i> <i>in parts per million.</i>
298	...	...	...	...	...	0.0005
300	...	...	...	...	...	0.0006
301	...	...	...	...	...	0.0007
302	...	...	...	...	...	0.0006

It is not possible, of course, to base any firm conclusion on these, but there seems to be no cause for alarm. This does not apply to wells or individual agricultural properties which could be at considerable risk owing to accidental spillage of chemicals.

The question of the fluoridation of our water supplies in order to protect children's teeth, was again considered during the year and the Board decided that the matter should not be proceeded with but might be reconsidered in a year's time. Controversy in this matter continues on the mainland and it will be interesting to see in which direction it is ultimately resolved.

SWIMMING POOLS

The attitude to the installation of private swimming pools in Guernsey differs from that in Jersey. Here we have 3 public and 9 private pools, whereas in Jersey there are 14 and 80-100 respectively. There may be various reasons for this, possibly pressure on space is greater here, perhaps they are regarded as too much of a luxury. The whole position in regard to private pools has altered on the mainland largely because of the more affluent society and partly because mass production and modern techniques have made them generally available at lower cost. Also, perhaps it is because they represent something of a "status symbol". On the whole, if they are looked after they are a welcome amenity, because people, and particularly young people, have more opportunity for swimming during the summer.

When pools are privately owned and operated, the responsibility for their maintenance in a clean and safe condition rests with the owners, but nevertheless it is desirable that health authorities should be willing to offer advice on how they can properly be maintained. As regards public swimming pools, it is essential that the health authority should see that the health of the users is adequately protected. Regular sampling of the water should be, and is carried out and attention given to changing rooms and sanitary conveniences. The suggestion has been made in past years that the possibility of establishing an all the year round, indoor, heated swimming pool should receive serious attention, particularly as a place which can be adapted for use for public assemblies, dances and other indoor activities. This suggestion still seems to be a good one.

SEWERAGE AND SEWAGE DISPOSAL

The year passed without any really serious problems although there were occasions when complaints were received over delays in emptying cesspits, particularly in times of heavy rainfall. The strength of the service was augmented to keep pace with the increased number of cesspits, the multiplication of which averages 300/400 a year. This is, of course, an unsatisfactory situation which can only be met ultimately by the installation of a main sewer, in which direction progress is being made. In this connection delay will aggravate the problem in more ways than one, since people who have built new houses with cesspits are not going to welcome being asked to undertake the additional cost of connecting to a main drain and thus virtually stultify expenditure on the original new cesspit. There are, of course, also the increasing problems inseparable from cesspit maintenance such as nuisance from leakage, nuisance arising from emptying, and steadily increasing road congestion not improved by a growing number of heavy vehicles. For good measure there is the burden of expense on the individual householder. As regards cesspit emptying, it had been realised in 1964 that the position regarding the emptying by exhaustor vehicles had become

critical on account of the shortage of points where adequate discharge into sewers was possible and the increasing volume of sewage for disposal.

After a good deal of controversy, the recommended Creux Mahie scheme was finally accepted and quite good progress was being made at the end of the year towards its construction. Despite the forebodings, it is unlikely that this outfall will cause any trouble to anyone in view of the safeguards additionally provided by the Island Engineer. Nevertheless, observations will be taken along the coast both east and west of the outfall to confirm this.

For some time now we have strongly advocated the use, on suitable sites, of the individual small sewage treatment plant. This means that if a small housing estate is planned it is dealt with, not by communal or individual cesspits, but by a small plant which will give a clean effluent for soakage into the land or disposal into an uncontrolled stream. The principle was in fact accepted by the Sewage Disposal Co-ordinating Committee for a scheme of this kind but has, in fact, not yet come to fruition.

BEACHES AND BAYS

During the past few years there has been a gradually awakening consciousness on the part of local authorities of seaside resorts on the mainland to the necessity of maintaining their beaches in a safe and attractive condition. After all, quite apart from any health obligations, the ever-increasing number of visitors to the seaside creates a certain amount of competition between resorts and those whose beaches are obviously polluted or littered soon lose favour with the public. In general the factors which render beaches unattractive are:

- (1) pollution of part of the beach and possibly the sea from sewage;
- (2) pollution from oil and other substances such as trade effluents;
- (3) ordinary litter always associated with crowds, but in particular broken bottles and tins which can be extremely dangerous;
- (4) lack of adequate sanitary conveniences or their defective maintenance, which can lead, of course, to the fouling of corners of the beach or rocks.

These are matters which have a direct bearing upon the health of visitors quite apart from the question of amenity.

Naturally, the health department must also keep a check on catering establishments, associated with beaches, which are often carried on with very primitive facilities. In our Island, public interest has developed in these problems in the same way as on the mainland and, with our very much larger number of visitors and our relatively numerous beaches, the economic implications of maintaining a high standard are obvious. Before considering our problems one might look at the several natural advantages the Island enjoys. In the first place the large area of beaches reduces overcrowding such as is seen on the mainland and this in turn makes the litter problem a less serious one. Secondly, our tides are strong and a great deal of natural cleansing takes place. Thirdly, and fortunately, artificial "amenities" are not provided. These are always productive of noise and litter. Our visitors neither want nor expect them but prefer the enjoyment of

natural surroundings. How then are we to ensure that we maintain a standard equal to or better than mainland resorts?

(1) *Sewage Pollution*

This question began to take form a few years ago and has not always been seen in quite the right perspective. There are only three of our bays which have been under any real criticism. As regards Fermain, some small seepage has undoubtedly taken place from time to time but work soon to be completed should eliminate this. As regards Petit Bôt, the problem is not so simple since some degree of pollution arises occasionally from multiple sources but here again the situation is kept under constant check and it is only occasionally that any nuisance occurs. Belgrave Bay has never been a great attraction for bathers and the ultimate pre-treatment at the outfall there will finally remove any cause for complaint.

As regards the much disputed Creux Mahie scheme, the various discussions which took place before its inception have resulted in a scheme of purification of the effluent which should give the highest possible degree of protection against any trouble arising from it in adjacent bays. To make doubly sure on this point it is planned to carry out regular tests of the purity of the sea at various points along the south coast. Taking the picture as a whole it could be said that the situation regarding possible sewage pollution of the sea in bays is as well or better under control as anywhere in the British Isles.

27

(2) *Oil Pollution*

Fortunately, trade effluents, which can be a problem in some places, do not worry us here. As regards floating oil some trouble has recently been experienced, particularly on the south coast, but the strong currents which surround us might help in reducing the nuisance. If it becomes serious in any way steps might be taken to treat the sea in the area concerned as is done in some places on the mainland where heavy pollution occurs.

(3) *Litter, etc.*

The problem of litter can be met by the provision of a reasonable number of receptacles and their regular emptying and the encouragement of the public to use them. In the main, the type of visitor who comes to the Island is co-operative. During the forthcoming visitor season it is planned to place all beaches under the especial charge of one health inspector and to consider the establishment of beach wardens to deal with litter and dangerous materials at the more popular beaches. This should control the situation adequately.

(4) *Sanitary Conveniences*

Several sanitary conveniences need some extension and steps are being taken in this direction. Certain repairs and improvements are also planned. At points where large crowds collect it is most desirable that attendants should be on duty. The presence of somebody in charge discourages sabotage and accordingly improves the services available. This is quite evident from the infrequency of complaints received in respect of supervised conveniences as compared with the large number regarding those not supervised.

PHARMACY, POISONS AND DANGEROUS DRUGS

There is little to report in this field during 1965. From time to time there are occasional references in the press and on television to the growth of drug addiction, particularly amongst young folk in England. This usually appears to start with the introduction of the individual to "reefers" or marijuana, which is in itself not a very serious drug. The trouble is that, once having accepted the idea of artificial stimulant, the individual is the more ready to move on to much more dangerous substances such as pethidine, morphine or heroin. It could be that the present abuse of tranquillisers and other drugs, which is encouraged by the National Health Service, plays its part in laying the way for addiction. Be that as it may, neither the problem of illicit sale or handling of drugs nor that of addiction is one which at present affects our Island. The main reasons are that import and distribution can be closely controlled, that the chemists are responsible and co-operative, and that in a small community odd behaviour or suspected peddling is soon noticed and reported. There is, of course, always the possibility of the odd small quantity being introduced by visitors from the mainland or from Jersey, but this need cause no anxiety. The addict who brings a supply is very unlikely to part with any of it, whereas the peddler is unlikely to flourish for the reasons stated above.

POISONOUS SUBSTANCES

28

During the year regular attendances were made at the Technical Sub-Committee on Poisonous Substances, held under the auspices of the Labour and Welfare Committee. This Sub-Committee has no easy task. Its broad mandate is to recommend measures for the control of poisonous substances used in agriculture, to ensure the safety of the agricultural worker and the public. This sounds simple, but there are several complications. The first is that every year the number and chemical complexity of these substances increases and many of them require quite elaborate precautions to be observed by the user. Secondly, the steadily increasing demand for heavier and more ample crops compels the grower constantly to be searching for more artificial aids. Thirdly, that it is difficult to keep pace with all this in the matter of legislation and official regulations. Added to all this, of course, is the fact that the simple agricultural worker does not take kindly to the rather elaborate, and to him somewhat unnecessary, precautions which are essential to his safety in handling dangerous poisons. It can be said that the work of this Sub-Committee proceeds smoothly and is keeping reasonable pace with current developments. Quite apart, of course, from the danger to the worker and to the people who consume vegetables, there is the fact that our water supply comes from the surface of the land, and theoretically at any rate it is possible for these poisons to find their way into wells, streams, and into the reservoir. Unfortunately, there are at present no simple tests which can demonstrate their presence either qualitatively or quantitatively. Steps are being taken, however, to send samples to a laboratory capable of carrying out such work, and results are expected in the new year.

RODENT CONTROL

For quite a long time now, the Public Health Department has recommended some changes in the organisation of our constant war upon the Island's rodent population. The main change advocated is that it should be possible for large

undertakings to arrange a contract with the Department for their services to be supplied at a fee. The main basis for this is that the firms who obtain the benefits and savings from our rodent services are really being subsidised by the individual householder. Further, free services of this kind do not provide either private individuals or firms with incentives to co-operate themselves in fighting the rat menace. No settlement in this matter has yet been reached. A recommendation, however, that an assistant should be provided for the Rodent Operator was in fact agreed. This is a most fortunate move forward, since during 1965 there was clear evidence that in some districts the rat population was becoming quite out of hand and the outlook for 1966 was quite alarming. It is, of course, recognised that the treatment of individual infested premises is extravagant and ineffective because many rats escape destruction by simply "moving house". The proper way is to treat quite big areas at once. It is hoped that the strengthened staff will be able to tackle this more effectively.

HOUSING AND PUBLIC HEALTH

Overcrowding

"There can be no doubt that serious overcrowding exists in parts of the Island and that highly congested districts are to be met with, especially in the urban areas.

"It is very difficult for the working man with a family to secure adequate housing accommodation, or indeed any accommodation at all, at a rental within his means, the demand for houses being so great, and most landlords prefer people without children or those with small families as their tenants. The result is that even very small houses are sublet and occupied by two or more families.

"The numbers of persons thus herded together is often so great that health, cleanliness, and morality cannot but suffer under these conditions.

"Few people are aware what a large number of honest, hard-working men and women are striving to bring up their children in decency and morality, under conditions of the greatest difficulty. Their brave struggles against adverse circumstances are but little known; the drunkard and the improvident too often represent the poorer classes in the popular mind. . . .

"The importance of this subject, and its bearing upon the health and well-being of future generations is so great, that I do not hesitate to bring it forward.

"It is the duty of an M.O.H. to be an enthusiast, perhaps even a dreamer. The Board, whose servant he is, will decide whether his suggestions are practicable or no."

All this applies to conditions in the Island not in 1965 but in 1903, just 62 years ago. It is interesting to see that similar comments are made in the reports of Medical Officers of Health for 1906, 1908, and later for 1920. So the problem is hardly a new one and it has also received mention in much more recent reports from 1961 onwards. It might seem, in view of these repeated exhortations, that sufficient emphasis had been laid in the past upon the paramount importance that attaches to decent accommodation in any community. Most people divide their lives between two main environments, their place of work and their home and since they spend longer in the latter, its influence cannot be exaggerated. With the decline in pulmonary tuberculosis in the Island and an improvement

in the general standard of public health it might be assumed that the urgency of the increased provision of decent housing had somewhat abated. Indeed, even when people do occupy damp, overcrowded and dirty accommodation, sometimes the damage to their health is not made obvious by repeated actual sickness. Nevertheless, the influence is there and is the more dangerous for being unseen and cumulative. Apart from psychological and other effects, overcrowding and squalor sometimes drive families to move out to such surroundings as caravans, sheds and shacks, which can be almost worse than old and dilapidated permanent structures. Better legal control regarding such occupation is being sought.

Now as to progress, the comparative figures are as follows:

At 31st December—

	1960	1961	1962	1963	1964	1965
Priority families... ..	17	17	15	16	8	10
Eviction cases	24	40	51	54	70	33
17 to 37 points	80	53	41	51	67	23
1 to 16 points	194	196	225	216	243	) 168
No points	160	175	192	185	208	
Totals	475	481	524	522	596	234

As at the end of 1965, this is certainly a brighter picture, the more so since a number of further units of accommodation may be provided in 1966. While these figures do show advances, they do not reflect the quality of accommodation and, while more people are undoubtedly obtaining accommodation, there is much need for a general and steady raising of its quality. This is the task of the Public Health Department, and with an increased staff it should be possible to require property owners to offer their tenants a generally better standard than has been tolerated previously.

HEALTH VISITING

Progress in this field has been even more encouraging than in the past. The number of Health Visitors was brought to five with the immediate prospect of a further recruitment in 1966, and this is a great advance. It is now possible for the size of the districts served by the Health Visitors to be reduced to an extent where much closer personal contact between the Visitor and the families can be maintained. The public is beginning to understand fully the purpose and nature of their work. Relations with the district nursing associations and their personnel have generally improved, as has co-operation with other social services. It will be remembered, of course, that a total strength of six Health Visitors only represents three full-time workers in that field, since half their time is devoted to schools. If the recommended ratio of one Health Visitor to 5,000 of the population were to be followed, our staff would be nine altogether, but much can be achieved on the present basis. Previous reports have referred to the desirability of having a Health Centre as a headquarters for the various functions of the Health Visiting Service. Plans are proceeding to this end.

TABLE VI

ANNUAL STATISTICS FOR HEALTH VISITORS, 1965

		District				
		Total	A	B	C	D
<i>Health Visiting</i>						
1. Primary visit 0-1 ...	...	632	148	194	144	94
2. Primary visit 1-5 ...	...	426	72	203	71	52
3. Revisit 0-1 ...	...	1,237	187	219	446	202
4. Revisit 1-5 ...	...	1,822	439	191	664	282
5. Old Persons ...	...	1,281	520	213	171	68
6. Mentally disordered ...	...	49	8	7	9	2
7. Problem families ...	...	91	11	11	17	10
8. Infectious households ...	...	221	42	35	36	18
9. Special and other visits ...	...	950	193	133	177	147
10. Non-effective visits ...	...	1,010	243	151	144	83
11. Total of visits ...	...	7,719	1,863	1,357	1,879	958
						1,662

Board of Health Clinics—Sessions

12. T.B. and chest ...	...	42	9	6	11	9	7
13. Inoculations and vaccinations ...	...	110	27	14	34	14	21
14. Staff Medicals ...	...	62	28	4	17	11	2
15. Infant Welfare ...	...	93	27	10	21	33	2
Phenistix tests carried out ...	...	425	136	128	147	0	14

Administration and Organisation Sessions for Board of Health and School Medical Services ...

	303	44	56	65	34	104
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ALDERNEY

Report from Dr. D. C. Bell

Population at last census . 1,472.

Epidemic Diseases

In July an epidemic of measles was introduced by some visitors to the Island and cases continued until the end of November. In all, 141 cases occurred of which 128 were children of school age. There were no serious complications. Other infectious diseases included 6 cases of chickenpox and 2 of glandular fever, the latter again brought in by visitors.

Vital Statistics

There were 17 births during the year, which included 2 sent to Guernsey for Caesarian section.

There were 16 deaths. The causes of death were:

Senility and myocardial degeneration	8
Bronchial Carcinoma	2
Coronary Occlusion	2
Cerebral Haemorrhage	1
Carcinoma Caecum	1
Carcinoma Abdominal Wall	1
Hypertensive Heart Failure	1

32

Poliomyelitis Vaccination

Following the outbreak of poliomyelitis on the mainland, there was a great demand for vaccination against this disease and 232 persons, which included 60 schoolchildren, received oral vaccine either as primary or revaccination.

Visits

The Island was visited by Mr. Ball, Senior Health Inspector, in April and again in July.

Sunshine and Rainfall

Recorded at Alderney Airport.

<i>Month</i>	<i>Sunshine hours</i>	<i>Rainfall inches</i>
January	45.0	6.35
February	74.2	0.24
March	144.7	3.40
April	165.9	1.25
May	183.1	1.18
June	223.3	2.33
July	191.8	1.57
August	197.4	2.09
September	138.7	3.01
October	139.2	0.96
November	68.6	7.09
December	42.3	7.89
	<hr/> 1,614.2 <hr/>	<hr/> 37.36 <hr/>

LABORATORY

Report from Mr. H. A. Wilson—Chief Technologist

Section 1: General Laboratory Tests

The total number of reports issued in this section was 11,712, an increase of 444. Specimens referred to Dorchester totalled 535, an increase of 13.

Section 2: Public Health Tests

Normal routine control testing followed the usual pattern except that fewer state controlled water sources were sampled but more well and private sources. No major incidents arose requiring laboratory investigation.

Section 3: Blood Transfusions and Grouping

	1964	1965
Pints donated	550	593
Donors requested	582	646
Pints cross matched	639	757
Requests for blood transfusions	362	404

There was a large increase in the demand for blood amounting to 118 pints.

33

In November, following conversations with the Alderney Medical Officer of Health, Dr. Bell, two of the staff went to Alderney and collected blood samples from a number of volunteer blood donors. From these we were able to select seven blood donors with specific blood antigens who could donate blood in Alderney if the circumstances compelled an immediate transfusion in that Island. Recent weather conditions whereby Alderney has been cut off from communication by both sea and air illustrate the providence of this provision.

The Blood Transfusion Service became self supporting in 1955, and during those ten years has steadily increased its content. Many technical advances have been made but, unfortunately, no provision for an adequate and proper reception centre for blood donors, doctors and technical staff has been provided, and operation difficulties are not uncommon. Public relations with the 770 registered blood donors must be improved by providing much better facilities than a hospital corridor. The demand for more blood donors is a constant feature in maintaining the service. We cannot afford to lose blood donors on the grounds of poor or improper facilities.

It is most encouraging that proposals are now well advanced to provide such a centre for a service of major importance, magnitude and growth rate.

It is also agreeable to report that the technical staff complement is now at full strength following a long period of serious deprivation. The appointment of two senior technicians has provided a more permanent staff structure with increased strength and should improve the quality and value of our basic and developmental work.

This year a record of 11,826 reports were issued.

INTRODUCTORY

I have the honour to present my section of the Annual Report for 1965, being my first full year in office as Chief Public Health Inspector. I should like to thank the members of the depleted inspectorial staff during the year, Messrs. S. R. Edwards and S. A. Le Tocq, for the loyal assistance they have given me throughout the year. I also extend my gratitude to Mr. W. P. Reid, the Department's long serving rodent officer for the valuable and painstaking work he has put in. Towards the end of the year, the Board of Health agreed to the appointment of a clerk/typist, and during October Miss G. Daycock was appointed to the position, and my thanks are due to her for the help given in the reorganisation of the administration of the public health inspectors' section. I would also like to say that I have appreciated the encouragement and courtesy extended by Members of the Board of Health and the Public Health Committee.

HOUSING

There has been considerable activity in the field of housing, investigating various categories of complaints relating to alleged unfitness, overcrowding, and complaints referring to disrepair.

The housing situation on this Island in relation to the artisan dwelling, is far from satisfactory. The extent of the problem is not known and without a full scale housing survey in the broad category of housing accommodation, one cannot even guess at the extent of its existence. It is sufficient to say that there is an apparently rapid decay of this mainly artisan class of tenanted dwelling, not only in the Town parishes but also extending to the country areas. What then is the cause of this decay? In addition to the basically unfit and badly arranged dwellings, it is due, in many cases, to the lack of maintenance and essential repair work which, over a number of years, has had a cumulative effect in producing a state of gross and chronic dilapidation to such an extent that now the only satisfactory way of dealing with such properties is by demolition or, more often, closure, thus placing at least a rather invidious moral onus on the Housing Authority in the allocation of suitable alternative accommodation for the displaced tenants.

The whole field of housing is a complex problem and needs to be tackled basically and imaginatively. Surely it is better to secure the preservation and protection of the Island's housing stock than for the States Housing Authority to be involved in the perhaps uneconomic capital expenditure in the provision of alternative accommodation. The answer could well be in the offering of financial inducements, in the form of grants, to the owners and landlords of salvable sub-standard properties to repair or to improve their properties by the provision of modern facilities and amenities subject, of course, to adequate safeguards and allied to a sensible approach to a realistic reappraisal of rent control so as to allow landlords a fair rent, but at the same time offering tenants adequate security of tenure and preventing an abuse of high rentals in existing un-controlled substandard and sub-amenity properties.

Proper housing is the prime social necessity and unless the people in need are adequately housed in fit dwellings at rents or within commitments they can afford, can we really say we are beginning to overcome our housing problem?

To take action under existing legislation by the service of a notice to determine tenancy (i.e. closing notice) is not constructive and serves very little useful purpose in that the property is not invariably rehabilitated for tenancy occupation and, in fact, sometimes works very much to the benefit of a perhaps unscrupulous landlord in relieving him of his statutory obligation to maintain his property in proper condition and could result in an availability of a valuable site to him.

Twenty-one properties, used for human habitation, were declared individually unfit and were subjected to closing action during 1965.

Coupled with my observations already stated, adequate powers must be available to ensure, by enforcement through realistic powers, the repair of houses and the abatement of structural environmental nuisances prejudicial to the health of the occupants.

REHOUSING

It is pleasing to note that there has been a great degree of co-operation from the Housing Authority in the rehousing of families displaced from properties which have had to be subject to closing notice procedure: this co-operation is appreciated.

35

But action taken by the Chief Public Health Inspector through the Medical Officer of Health is sometimes necessarily geared to the housing allocation availability of the Housing Authority, i.e. what is expedient rather than what is required by statutory action and enforcement.

HOUSING—other observations

Another problem which is being discovered is that of the house originally suitable for single family occupation now let in multiple occupation with congested sleeping conditions and lack of, or deprivation of, or restriction of basic amenities and service facilities. It seems again that without realistic enforcement powers, little formal action can be taken to any degree of success: this, of course, stresses the fundamental accommodation problem.

Another anomaly is the case of the unfit owner/occupied property. Such property could be grossly unfit by all standards; where such a property is tenanted one could proceed by the issue of a closing notice, but in the case of the owner/occupied property, one cannot place an enforceable closing notice on the property and neither can the co-operation of the Housing Authority in rehousing be reasonably sought. Does it not seem that if a man tries to look after his own housing interests he could well be prejudiced?

HOUSE IMPROVEMENTS

Two properties previously subject to closing notice have, in fact, been rehabilitated and made fit for human habitation: closing orders therefore being revoked. Two further applications for consideration of revocation of closing notices have been received. No formal proposals had been finalised and no work had been started before the end of the year.

The connection of dwelling properties to States water mains service, wherever practicable, is the aim of the Public Health Department and during 1965 five properties previously drawing water from private water supply have been connected to the mains service.

REMEDYING OF ITEMS OF DISREPAIR IN DWELLINGS

A total of 253 items of structural works of repair, mainly of nuisance nature, were dealt with by informal negotiation and verbal agreement.

MOVEABLE DWELLINGS/CARAVANS

Four applications were received in respect of siting of caravans, mainly in connection with the use of a permanent dwelling within the site. These proposed sites were inspected and commented upon as necessary.

ATMOSPHERIC POLLUTION

There was no serious evidence of major atmospheric pollution by smoke, grit, dust or particulate matter. The Island is fortunate indeed in that clean air is an almost tangible thing, particularly during the summer months.

GENERAL SANITATION—WATER SUPPLY

With respect to States mains supplies, as to be expected, supplies of water were adequate quantitatively, and bacteriologically the supply was satisfactory and wholesome.

BACTERIOLOGICAL SAMPLES

38 samples of mains water were taken and all were found satisfactory on bacteriological examination.

CHEMICAL

85 samples of private well water were taken, 9 were declared unsatisfactory.

In the case of unsatisfactory results, the proposed users of such supplies were advised of the necessity of suitable purification apparatus being installed in connection with its use, particularly for drinking and culinary purposes. If the States Water Board connection is practicable, this is most strongly recommended.

HOUSE DRAINAGE: CESSPOOLS: SEPTIC TANKS:

A quite considerable amount of work was again carried out by inspectors in this field, sometimes involving investigatory work requiring several visits to negotiate informally the abatement of nuisances occurring in unsatisfactory drainage arrangements, mainly defective cesspools, soakaways, etc. I cannot emphasize too strongly that strictly enforceable legislation is desirable to help to overcome this problem.

REFUSE STORAGE, COLLECTION AND DISPOSAL

As in 1964, this service was carried out with no serious or pursuable complaint of public health nuisance. Refuse disposal was effected at the States tip

by controlled tipping with application of necessary cover at the end of each working day. Regular routine visits were made by the Inspectors and also by the Rodent Officer, carrying out preventive treatments as necessary.

It is perhaps pertinent to remark that although controlled tipping is certainly the most economical method of refuse disposal and can perhaps result in the reclamation of land, the question of availability of future suitable sites for tipping must be looked at seriously with a view to future planning of the refuse disposal programme.

PUBLIC CONVENIENCES

Routine visits were made during 1965 to all public conveniences. No serious defects were found.

SWIMMING POOLS

The number of swimming pools on the Island is increasing: towards the end of the year a composite sampling kit was made available to the Department: such equipment will be used to test the pool waters for satisfactory levels of purification treatment, invariably chlorination, and also to determine the pH value of the waters. These tests are of "on the spot" type and results can be given instantly and advice offered with respect to remedial treatment.

In the case of private pools, it is hoped to apply similar tests with the voluntary co-operation of the owners/users.

FOOD INSPECTION AND CONTROL: FOOD PREPARATION PREMISES: FOOD HYGIENE:

As previously indicated in my report for the year 1964, very little activity in this most important aspect of environmental health could be maintained during 1965 without additional staff. With the arrival in 1966 of two additional Public Health Inspectors technically qualified and experienced in the broad field of food inspection and food hygiene, a very active, comprehensive and progressive programme will be undertaken. All food traders and food handlers will be offered advice, guidance, criticism and encouragement.

FOOD OFFENCES

Five offences, relating in one case to unsound food offered for sale, and in four cases to articles of food containing extraneous matter, were brought to the notice of the Department and investigated during 1965, and referred to the Public Health Committee. Warning advice was given as necessary and the future co-operation of the traders concerned was sought.

It is perhaps pertinent to comment that in order to protect public health interests, members of the public should be encouraged to report instances of unsoundness and poor quality in foodstuffs, as it is only with the co-operation of the public that many food offences are brought to light and able to be investigated.

SPECIAL CATEGORY VISITS IN RELATION TO FOOD PREMISES

Inspections of Guest Houses and Hotels

	(dual visits with Tourist Committee Inspectors)	116
ditto.	with Building Inspectors	33
Visits to farms		79
States Dairy and Milk Depots		120
Number of milk samples taken		48

The following Table refers to visits and inspections made by the
PUBLIC HEALTH INSPECTORS in the field of FOOD HYGIENE

Milk	48
Ice Cream	68
Food Consumer Complaints	28
Food for Voluntary Surrender and Disposal	165
Food Premises:	
Cafés	34
Restaurants	25
Bakehouses	31
Clubs	4
Canteens	1
Fish and Chip Shops	5
Grocers	14
Greengrocers	4
Butchers	10
Confectioners	7
Retail Markets	5
Food Storage Depots	10
Slaughterhouses	1
Licensed Premises	17

ICE CREAM SAMPLING

68 samples of ice cream	11 Local Manufacture.
	57 Non-local.
Grade I 59)	Satisfactory.
Grade II 4)	
Grade III 4)	These were mainly in the soft mix category—advice given as necessary. Repeat samples showed satisfactory results.
Grade IV 1)	

FOOD SURRENDERED AS UNSOUND OR UNFIT FOR HUMAN
CONSUMPTION

Fish

Bream—48 lbs.
Pilchards—6 tins
Salmon—7 tins

Sardines—3 tins
Fish—1 tin
Shrimps—1 tin
Crab—4 tins

Fruit and Fruit Juices

Apricots—17 tins
Apples—6 lbs.
Blackcurrants—4 tins
Cherries—4 tins
Currants—8 lbs.
Fruit Salad—8 tins
Fruit—2 cases/24 tins
Fruit Cocktail—3 tins
Fruit Juice—5 tins
Grapefruit—33 tins
Mandarin Oranges—14 tins
Melons—9 No.
Orange Juice—8 tins
Peaches—56 tins
Pears—38 tins
Pineapples—19 tins
Prunes—1 tin
Plums—9 tins
Raisins—7 lbs. and 1 tin
Tomatoes—50 tins

Jams and Marmalades

Golden Shred—1 jar
Marmalades—41 lb. jars
Jam—2 lbs.
Sweetcurd—1 pkt.

Meats

Bacon—837 lbs.—1,200 pkts.—22 cases
Biddy Steak—1 tin
Chicken—5 No.—1 tin
Chicken Croquettes—14 No.
Chicken Mince—2 tins
Corned Beef—29 tins
Beef—22 lbs.
Beef Chops—1 pkt.—8 lbs.
Duck—6 tins
Frankfurter Sausages—40 x 24 lbs.
Gammon—14 lbs.
Ham—4,781½ lbs.
Minced Pork—8 lbs.
Ox Meat—1 tin
Ox Tongue—14 tins
Paté de Foie—18 tins
Pork—1,600 lbs.—11 cases
Pork Pies—1 No.
Pork Luncheon Meat—244 tins
Spam—2 lbs.
Sausages—213 lbs.
Sausage Meat—2 lbs.
Steak—7 tins
Tenderloin—3 lbs.
Veal—12 lbs.

Vegetables

Baked Beans—31 tins
Beetroot—2 jars
Carrots—31 lbs.—3 tins
Cauliflower—90 lbs.
Celery Hearts—1 tin
Green Beans—13 tins
Green Peas—18 tins—240 lbs.
Onions—1 gallon jar
Sauerkraut—10 tins
Vegetables—16 cases—7 tins (mixed)

Other

All Bran—1 pkt.
Butter—9 lbs.
Cheese—309 lbs.—6 cartons
Chipples—424 pkts.—52 cases
Cooking Salt—1 cwt.
Creamed Rice—5 tins
Crisps—583 bags
Coffee—1 tin
Creme de Menthe—1 tin
Cream—1 tin
Cereal—1 case—1 pkt.
Farley's Milk—5 cartons
Farlene—54 cartons
Farley's Rusk—1 pkt.
Flour—3 pkts.
Grill—mixed—1 tin
Heinz Pudding—1 No.
Ice Cream—409 portions
Lard—30 lbs.
Lemon Squash—3 bottles
Lime Juice—2 tins
Milk—54 tins
Nesquick—2 tins
Oatmeal—11 pkts.
Porridge Oats—1 pkt.—1 lb.
P.H. Juice—2 tins
Pickles—2 jars
Ribena—1 bottle
Rice Crispies—2 tins
Ravioli—21 tins
Rice—3 tins—7 lbs.
Rice Pudding—23 tins
Soup—4 tins—14 pkts.
Spaghetti—2 tins
Swiss Roll—1 pkt.
Shredded Wheat—9 pkts.
Sugar—31 lbs.
Sweets—1½ lbs.
Tea—2 lbs.
Tib Roll—1 tin
Yoghourt—48 cartons

The following table refers to various aspects of work carried out by the
Public Health Inspectors during 1965

House inspections	...	...	...	...	...	...	...	172
Houses re-inspected	...	...	...	...	...	...	...	192
Overcrowding complaints	...	...	...	...	...	...	...	26
Workplaces inspected	...	...	...	...	...	...	...	16
Factories	...	...	...	...	...	...	...	3
Schools	...	...	...	...	...	...	...	8
Cesspools	...	...	...	...	...	...	...	159
Septic tanks	...	...	...	...	...	...	...	32
Streams	...	...	...	...	...	...	...	61
Ditches	...	...	...	...	...	...	...	112
House drainage	...	...	...	...	...	...	...	283
Public sewers	...	...	...	...	...	...	...	33
Plans inspected on site	...	...	...	...	...	...	...	12
Drain tests applied	...	...	...	...	...	...	...	60
Verminous premises	...	...	...	...	...	...	...	102
Verminous persons	...	...	...	...	...	...	...	1
Verminous articles	...	...	...	...	...	...	...	1
Refuse accumulations	...	...	...	...	...	...	...	87
Controlled tips	...	...	...	...	...	...	...	34
Smoke emissions	...	...	...	...	...	...	...	5
Atmospheric nuisances	...	...	...	...	...	...	...	36
Rodent control	...	...	...	...	...	...	...	32
Infectious disease	...	...	...	...	...	...	...	—
Complaints referred from Parochial Authority	...	...	...	...	...	...	...	16
Public conveniences	...	...	...	...	...	...	...	60
Dual visits with other officers	...	...	...	...	...	...	...	84
Caravans	...	...	...	...	...	...	...	8
Camping sites	...	...	...	...	...	...	...	10
Visits to Herm (inspections)	...	...	...	...	...	...	...	15
Visits to Alderney (inspections)	...	...	...	...	...	...	...	22
Visits to Jethou	...	...	...	...	...	...	...	1
Appointments in office	...	...	...	...	...	...	...	61
Appointments outside office	...	...	...	...	...	...	...	206
Miscellaneous	...	...	...	...	...	...	...	123
Unsuccessful visits (no access)	...	...	...	...	...	...	...	44
Bays and beaches	...	...	...	...	...	...	...	15
Wasp nuisances	...	...	...	...	...	...	...	113
Insect nuisances	...	...	...	...	...	...	...	2
Keeping of animals	...	...	...	...	...	...	...	3
Watercourses	...	...	...	...	...	...	...	3
Water supply	...	...	...	...	...	...	...	2

Samples taken for Analysis by States Analyst

<i>Type of Sample</i>	<i>Reason</i>	<i>Result</i>
I Tetrapak containing milk	Consumer complaint of extraneous matter.	Blackish powdery substance likely to be printers' ink—not harmful. ACTION: complaint referred to States Dairy. Complainant advised.
II Part of Tetrapak of milk	Consumer complaint of suspected added water.	Genuine milk.
III Plastic Syringe	Found in an Island Private Club (query: drug content)	Nothing harmful found.
IV Brown Bread	Consumer complaint	Small amount of dye present — not harmful — complainant advised.
V Salt	Retailer complaint	Iron in ferrous state found — particular stock of salt voluntarily surrendered.
VI Sliced Bread	Consumer complaint	Iron oxide stains due to rust in dough — warning letter to bakery.

41

One further matter investigated referred to a complaint of a needle said to have been taken from a consumer milk pack. This matter was referred to the States Dairy for further investigation: the circumstances of milk handling, packing and distribution would make such an offence unlikely at the Dairy, however.

FOOD SAMPLES—Bacteriological Examination.

MILK—Consumer

46 samples Tetrapak milk taken for examination to determine efficient pasteurisation.

All were satisfactory.

4 samples taken direct from a cow were declared unsatisfactory.

The producer farmer was advised on proper dairy hygiene: subsequent samples proved satisfactory.

OTHER FOODS

2 Meat Pies
both satisfactory.

1 Tinned Salmon (opened)
satisfactory.

SAMPLES taken during investigation into probable food poisoning outbreak.

- Mains water (each tap)
- 2Ice cream servings
- Swabs from:
- (a) can opener
- (b) kitchen knives
- (c) drying cloth
- All results negative and satisfactory.

Bacteriological Sampling of Water

Source				Number of Samples		
				Total	Satisfactory	Unsatisfactory
Mains Supply	...	...	...	38	38	
Well Water	...	...	...	85	76	9
Quarries	...	...	...	5	5	
Swimming Water	...	...	...	6	6	
Washing-Up Water	...	...	...	2	2	
Herm	...	...	...	26	18	8
Jethou	...	...	...	2	2	
Sark	...	...	...	15	4	11
Streams	...	...	...	7	3	4
Sea Water (Bays)	1	1	
Douit Water	1	1	

Chemical Sampling of Water

Mains Water	2	1	1
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Note on Samples taken in Sark

These are bacteriologically examined as matter of courtesy following requests invariably from prospective consumer and from the Island Doctor. Results, as soon as available, and advice, as necessary, are notified to the persons concerned.

DISINFESTATIONS:

Dwelling houses, including 31 States dwellings	...	...	64
Commercial premises	...	...	3

With respect to the disinfestation of dwellings, this refers almost entirely to flea infestations and it is significant to record that many infestations are recurrent complaints indicating that, without the facilities of a properly equipped cleansing station where personal, clothing and bedding disinfestation can take place, the ultimate eradication of this vermin nuisance cannot be otherwise reasonably attained.

RODENT CONTROL

Number of complaints of surface and other infestations	...	...	2,438
Number of visits made, investigations carried out	...	...	2,808
Treatments carried out at:—			
Domestic premises	...	...	801
Non-domestic (growers) and commercial premises	...	...	1,175
Secondary treatments	...	...	232

Comments on Rodent Control

This service continued through the year on an “on complaint” basis, this being the only practicable way of dealing with the problem with the service of only one operator. As mentioned in previous reports, this cannot and will not result in any dramatic reduction of the Island’s rat infestation problem. The Board considered this difficulty of inadequate rodent staff and towards the end of the year the appointment of an additional Rodent Operator was agreed, to start duty early in 1966.

It is significant to note that the statistics quoted show no great change from 1964, and of special mention is the number of treatments applied in respect of non-domestic premises, almost exclusively growing premises, where no fewer than 1,175 treatments were carried out following requests for assistance. The question of recommending the introduction of a chargeable service for such premises must receive very serious consideration.

43

WASP DESTRUCTION

113 wasps nests were treated or destroyed during the year.

This is a service for which the Board and its officers are not statutorily responsible, but, nevertheless, where advice and assistance are needed reasonable endeavours are made to provide a form of service where this is practicable: unfortunately, members of the public “get the word” that the Board of Health will “do it for you” and thus this service becomes established. The position should be regularised.

HERM

This Island was visited on four occasions by the Public Health Inspectors and on three occasions by the Rodent Operator.

The food premises operating on the Island were inspected and found to be reasonable: but suggestions and improvements relating to food hygiene practice were made, and it is pleasing to record the ready co-operation of the Tenant of Herm in these matters. Similar co-operation has been forthcoming in respect of the safeguarding of the Island’s water. Numerous samplings for bacteriological examination with unsatisfactory results indicated possible danger at some points of the water supply. Suitable means of the addition of chlorine have been satisfactorily applied.

The public sanitary accommodation work between Belvoir and Shell beaches was put in hand during the year. General drainage arrangements were found to be reasonably satisfactory.

ALDERNEY

This Island was visited twice by the Chief Public Health Inspector during 1965. Various categories of inspections were made and advice and guidance offered. One's professional attitude may be said perhaps to be tempered by the small size and population of the Island and this may be looked upon as the main criterion in preventive public health measures. Illustrative of this, mention should be made of the real need to effectively safeguard the Island's milk supply by pasteurisation, and its retailing other than distribution by open service cans. What is the answer to this pressing problem? Can the aims of public health be achieved compatible with reasonable workable economy? Health measures should recognise no cost!

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Population by Age-groups, 1931 — 1961

Guernsey and Adjacent Islands

47

APPENDIX II
SELECTED GUERNSEY HEALTH STATISTICS

	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965
Infant Mortality Rate per 1,000 Live Births	19.5	25.1	29.5	14.2	32.6	31.6	13.1	26.9	19.9	33.0	22.3	19.7	14.3	21.1	17.6	28.5	21.32	19.61
Neo-Natal Deaths Rate per 1,000 Live Births	12.5	17.6	22.6	9.0	20.3	19.4	8.7	16.5	14.2	16.5	18.1	14.1	13.0	17.1	11.3	24.9	15.71	13.48
Still Births Rate per 1,000 Live Births	24.2	23.9	20.1	14.2	21.7	20.6	13.1	8.9	24.2	18.0	22.3	19.7	22.1	23.8	17.6	15.44	7.86	13.48
Pulmonary T.B. Rate per 1,000 ..	0.79	0.61	0.42	0.27	0.21	0.18	0.11	0.14	0.19	0.12	0.04	0.15	0.11	0.07	0.04	0.06	0.03	0.07

APPENDIX III

DEATHS BY AGE GROUPS AND CAUSES — 1965

Intern List No.	Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75 +		Total all Ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
002	GROUP I																			
	<i>Infective and parasitic Diseases:</i>																			
	Pulmonary Tuberculosis	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—	2	—	2
	Totals: GROUP I	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—	2	—	2
	GROUP II																			
	<i>Cancer and other Tumours</i>																			
145	Oral Nasopharynx	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1
150	Oesophagus	—	—	—	—	—	—	—	—	—	—	1	—	3	—	1	2	5	2	7
151	Stomach	—	—	—	—	—	—	—	—	—	—	5	—	—	2	4	2	9	4	13
153	Large intestine, except rectum ...	—	—	—	—	—	—	—	—	—	—	1	1	—	2	3	3	4	6	10
154	Rectum	—	—	—	—	—	—	—	—	—	—	1	—	1	1	1	1	3	2	5
155	Biliary passages and liver (primary site)	—	—	—	—	—	—	—	—	—	—	1	1	—	—	1	—	2	1	3
156	Liver (secondary and unspecified) ...	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	2	—	2
157	Pancreas	—	—	—	—	—	—	—	—	—	—	—	1	2	1	1	1	3	2	5
158	Peritoneum	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1
162	Bronchus and trachea, and of lung specified as primary	—	—	—	—	—	—	—	—	4	—	5	—	2	—	2	—	13	—	13
163	Lung, unspecified as to whether primary or secondary	—	—	—	—	—	—	—	—	1	—	2	—	3	—	3	—	9	—	9
170	Breast	—	—	—	—	—	—	—	—	—	2	—	2	—	2	—	1	—	7	7
Carried forward		—	—	—	—	—	—	—	—	5	2	17	5	11	10	16	10	49	27	76

Intern List No.	Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75+		Total all Ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	<i>Brought forward</i>	—	—	—	—	—	—	—	—	5	2	17	5	11	10	16	10	49	27	76
	<i>GROUP II (Continued)</i>																			
171	Cervix uteri	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	2
174	Uterus unspecified	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
175	Ovary, Fallopian tube and broad ligament	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
176	Other and unspecified female genital organs	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
177	Prostate	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	7
180	Kidney	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
181	Bladder and other urinary organs ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
191	Skin	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
193	Brain and other parts of nervous system	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
199	Other and unspecified sites	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	7
204	Leukaemia and eleukaemia	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
232	Unspecified nature of breast	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
	Totals: GROUP II	—	—	—	—	1	—	—	—	5	2	18	6	17	14	24	17	65	39	104

Intern List No.	Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75 +		Total all Ages		Grand Total 1965	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
	GROUP III <i>Allergic, endocrine system, metabolic and nutritional diseases</i>																				
241	Asthma	—	—	—	—	—	—	—	—	—	—	—	—	3	1	—	—	3	2	5	
253	Myxoedema and cretinism	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	1	
260	Diabetes mellitus	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	1	1	2	
286	Other avitaminoses and nutritional deficiency states	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1	
	Totals: GROUP III	—	—	—	—	—	—	—	—	—	1	—	1	5	2	—	—	5	4	9	
	GROUP IV <i>Diseases of the blood and blood- forming organs</i>																				
292	Other anaemias of specified type ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1	
294	Polycythaemia	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1	
	Totals: GROUP IV	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	1	1	2	
	GROUP VI <i>Diseases of the nervous system and sense organs</i>																				
331	Cerebral Haemorrhage	—	—	—	—	—	—	—	—	—	1	6	3	2	5	2	11	10	20	30	
332	Cerebral embolism and thrombosis	—	—	—	—	—	—	—	—	—	—	—	1	4	3	7	24	11	28	39	
334	Other and ill-defined vascular lesions affecting central nervous system	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	2	4	2	6	
345	Multiple sclerosis	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1	
	<i>Carried forward</i>	—	—	—	—	—	—	—	—	—	—	1	7	4	7	8	12	37	26	50	76

Intern List No.	Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75 +		Total all Ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	<i>Brought forward</i>	—	—	—	—	—	—	—	—	—	1	7	4	7	8	12	37	26	50	76
	<i>GROUP VI (Continued)</i>																			
352	Other cerebral paralysis	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	1
353	Epilepsy	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1
356	Motor neurone disease and muscular atrophy	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	2	—	2
	Total: GROUP VI	1	—	—	—	—	—	—	—	—	1	8	4	8	9	12	37	29	51	80
	<i>GROUP VII</i>																			
	<i>Diseases of the circulatory system</i>																			
410	Diseases of mitral valve	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—	1	1	2
411	Diseases of aortic valve specified as rheumatic	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
420	Arteriosclerotic heart disease, including coronary disease	—	—	—	—	—	—	—	—	3	—	30	3	22	12	22	17	77	32	109
421	Chronic endocarditis, not specified as rheumatic	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1
422	Other myocardial degeneration	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	1
433	Functional disease of heart	—	—	—	—	—	—	—	—	—	—	—	—	2	2	5	11	7	14	21
434	Other and unspecified diseases of heart	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2	2
440	Essential benign hypertensive heart disease	—	—	—	—	—	—	—	—	1	1	1	1	6	6	7	10	15	18	33
	<i>Carried forward</i>	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
		—	—	—	—	—	—	—	—	4	1	31	5	31	21	36	41	102	68	170

Intern List No.	Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75 +		Total all Ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	<i>Brought forward</i>	—	—	—	—	—	—	—	—	4	1	31	5	31	21	36	41	102	68	170
	<i>GROUP VII (Continued)</i>																			
443	Other and unspecified hypertensive heart disease	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	1	2
444	Essential benign hypertension	—	—	—	—	—	—	—	—	—	—	2	—	—	4	3	4	5	8	13
445	Essential malignant hypertension	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	2	2
450	General arteriosclerosis	—	—	—	—	—	—	—	—	—	—	1	—	—	2	1	2	2	4	6
456	Other diseases of arteries	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	2	—	2
465	Pulmonary embolism and infarction	—	—	—	—	—	—	—	—	—	—	1	—	—	2	—	3	1	5	6
	Totals: GROUP VII	—	—	—	—	—	—	—	—	4	1	36	6	31	30	42	51	113	88	201
	<i>GROUP VIII</i>																			
	<i>Diseases of the respiratory system</i>																			
480	Influenza with pneumonia	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	1
481	Influenza with other respiratory manifestations, and influenza unqualified	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
482	Influenza with digestive manifestations, but without respiratory symptoms	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1
490	Lobar pneumonia	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	1
491	Bronchopneumonia	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	1	1	2	3
492	Primary atypical pneumonia	1	—	—	—	—	—	—	—	—	—	4	2	1	2	6	10	12	15	27
493	Pneumonia, other and unspecified	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—	2	—	2
	<i>Carried forward</i>	1	—	—	1	—	—	—	—	1	—	6	4	3	3	8	13	19	21	40

Intern List No.	Cause of Death	0 - 1		1 - 4		5 - 14		15-24		25-44		45-64		65-74		75 +		Total All Ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	<i>Brought forward</i>	1	—	—	1	—	—	—	—	1	—	6	4	3	3	8	13	19	21	40
	<i>GROUP VIII (Continued)</i>																			
500	Acute bronchitis	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1
501	Bronchitis unqualified	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1	—	3	—	3
502	Chronic bronchitis	—	—	—	—	—	—	—	—	—	—	3	—	1	1	2	2	6	3	9
522	Pulmonary congestion	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
525	Other chronic interstitial pneumonia	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—	1	1	2
527	Other diseases of lung and pleural cavity	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	2	2	3	5
	Totals: GROUP VIII	1	—	—	1	—	—	—	—	1	—	10	4	3	6	13	17	33	28	61
	<i>GROUP IX</i>																			
	<i>Diseases of the Digestive System</i>																			
540	Ulcer of stomach	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1
541	Ulcer of duodenum	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1
570	Intestinal obstruction without mention of hernia	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	1	1	2	3
571	Gastro-enteritis and colitis except ulcerative, age 4 weeks and over ...	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1
572	Chronic enteritis and ulcerative colitis	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1
573	Functional disorders of intestines ...	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	1
576	Peritonitis	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1
578	Other diseases of intestines and peritoneum	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1
581	Cirrhosis of liver	—	—	—	—	—	—	—	—	—	—	2	—	1	—	1	—	4	—	4
	<i>Carried forward</i>	1	—	—	—	—	—	—	—	—	1	4	—	4	—	2	2	11	3	14

Intern List No.	Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75+		Total All Ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	<i>Brought forward</i>	1	—	—	—	—	—	—	—	1	—	4	—	4	—	2	2	11	3	14
	<i>GROUP IX (Continued)</i>																			
582	Suppurative hepatitis and liver abscess	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
583	Other diseases of liver	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1
587	Diseases of pancreas	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	1
	Totals: GROUP IX	1	—	—	—	—	—	—	—	1	—	4	—	4	—	4	3	13	4	17
	<i>GROUP X</i>																			
	<i>Diseases of genito-urinary system</i>																			
590	Acute nephritis	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1
592	Chronic nephritis	—	—	—	—	—	—	—	—	—	—	1	—	—	1	1	—	2	1	3
593	Nephritis not specified as acute or chronic	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1
600	Infections of kidney	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	1	2
602	Calculi of kidney and ureter	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1
	Totals: GROUP X	—	—	—	—	—	—	—	—	—	—	2	—	—	2	2	2	4	4	8
	<i>GROUP XII</i>																			
	<i>Diseases of the Skin and Cellular Tissue</i>																			
704	Pemphigus	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1
	Totals: GROUP XII	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1

Intern List No.	Cause of death	0-1	1-4	5-14	15-24	25-44	45-64	65-74	75+	Total All Ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	
	GROUP XIII <i>Diseases of the Bones and Organs of Movement</i>											
731	Osteitis deformans	—	—	—	—	—	—	I	—	I	—	I
	Totals: GROUP XIII	—	—	—	—	—	—	I	—	I	—	I
	GROUP XIV <i>Congenital Malformations</i>											
752	Congenital hydrocephalus	I	—	—	—	—	—	—	—	I	—	I
754	Congenital malformations of circulatory system	—	—	—	—	—	—	—	—	—	I	I
	Totals: GROUP XIV	I	—	—	—	—	—	—	—	I	I	2
	GROUP XV <i>Certain diseases of early infancy</i>											
761	Other birth injury	—	—	—	—	—	—	—	—	—	I	I
762	Postnatal asphyxia and atelectasis ...	I	—	—	—	—	—	—	—	I	4	5
763	Pneumonia of newborn	I	—	—	—	—	—	—	—	I	I	2
774	Immaturity with mention of any other subsidiary condition	—	—	—	—	—	—	—	—	—	I	I
776	Immaturity, unqualified	2	—	—	—	—	—	—	—	2	I	3
	Totals: GROUP XV	4	—	—	—	—	—	—	—	4	8	12

Intern List No.	Cause of Death	0 - 14										15-24		25-44		45-64		65-74		75+		Total All Ages		Grand Total 1965
		0 - 1		1 - 4		5 - 14		15-24		25-44		45-64		65-74		75+		Total All Ages						
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F					
	GROUP XVI <i>Symptoms, senility, and ill-defined con- ditions</i>																							
786	Symptoms referable to genito-urinary system	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	
792	Uraemia	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	
794	Senility without mention of psychosis	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	43	
	Totals: GROUP XVI	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	47	
	GROUP N.XVII <i>Alternative classification of accidents, poisonings, and violence (nature of injury)</i>																							
N.803	Other and unqualified skull fractures	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	
N.854	Subarachnoid, subdural and extra- dural haemorrhage following injury (without mention of cerebral laceration or contusion)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	
N.855	Other and unspecified intracranial haemorrhage following injury (with- out mention of cerebral laceration or contusion)	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	
N.856	Head injury of other and unspecified nature	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	
N.862	Injury to other and unspecified intra- thoracic organs	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	
	<i>Carried forward</i>	—	—	—	—	—	—	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	7	

Intern List No.	Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75+		Total All ages		Grand Total 1965
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	<i>Brought forward</i>	—	—	—	—	—	—	3	—	1	—	1	—	1	1	—	—	6	1	7
	<i>GROUP N.XVII (Continued)</i>																			
N.948	Burn involving face, head and neck with trunk and limb(s)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1
N.969	Poisoning by other gases and vapours	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	1
N.971	Poisoning by barbituric acid and de- rivatives	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	1
N.990	Drowning and non-fatal submersion	—	—	—	—	—	—	1	—	3	—	—	1	—	—	—	—	4	1	5
N.991	Asphyxia and strangulation	—	—	—	—	—	—	1	—	1	—	—	1	1	1	—	—	3	2	5
N.999	Adverse reaction to other therapeutic procedures	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	1
	Totals: GROUP N.XVII	—	—	—	—	—	—	5	—	6	1	1	2	2	2	—	2	14	7	21

DEATHS BY AGE GROUPS—SUMMARY

Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75+		Total all Ages	Total 1965	Total 1964
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
GROUP I: Infective & parasitic diseases	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—	2	2	4
GROUP II: Cancer and other tumours	—	—	—	—	1	—	—	—	5	2	18	6	17	14	24	17	65	39	100
GROUP III: Allergic, endocrine system, metabolic & nutritional diseases ...	—	—	—	—	—	—	—	—	—	1	—	1	5	2	—	—	5	4	9
GROUP IV: Diseases of the blood & blood forming organisms	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	1	1	2
GROUP V: Mental, psycho neurotic & personality disorders	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
GROUP VI: Diseases of the nervous system and sense organs	1	—	—	—	—	—	—	—	—	1	8	4	8	9	12	37	29	51	80
GROUP VII: Diseases of the circulatory system ...	—	—	—	—	—	—	—	—	4	1	36	6	31	30	42	51	113	88	201
GROUP VIII: Diseases of the respiratory system ...	1	—	—	1	—	—	—	—	1	—	10	4	8	6	13	17	33	28	61
GROUP IX: Diseases of the digestive system	1	—	—	—	—	—	—	—	—	1	4	—	4	—	4	3	13	4	17
GROUP X: Diseases of the genito-urinary system	—	—	—	—	—	—	—	—	—	—	2	—	—	2	2	2	4	4	8
Carried forward	3	—	—	1	1	—	—	—	10	6	80	21	74	63	97	128	265	219	484
																			455

Cause of Death	0-1		1-4		5-14		15-24		25-44		45-64		65-74		75+		Total all Ages	Total 1965	Total 1964
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F			
<i>Brought forward</i>	3	—	—	1	1	—	—	—	10	6	80	21	74	63	97	128	219	484	455
GROUP XI: Delivery and complications of pregnancy, childbirth & the puerperum	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
GROUP XII: Diseases of the skin and cellular tissue	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—
GROUP XIII: Diseases of the bones and organs of movement	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	—
GROUP XIV: Congenital malformations	1	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	2	3
GROUP XV: Certain diseases of early infancy	4	8	—	—	—	—	—	—	—	—	—	—	—	—	—	4	8	12	13
GROUP XVI: Symptoms, senility and ill-defined conditions	—	—	—	—	—	—	—	—	—	—	—	—	—	—	16	31	31	47	51
GROUP N.XVII: Alternative classification of accidents, poisonings & violence (nature of injury) ...	—	—	—	—	—	5	—	—	6	1	1	2	2	2	—	2	14	21	17
TOTALS:	8	8	—	2	1	5	—	—	16	7	81	23	77	65	113	162	301	568	540

Causes of Infant Deaths—Under one month

		M	F	Total
752	Congenital hydrocephalus	1	—	1
761	Other birth injury	—	1	1
762	Post-natal asphyxia and atelectasis	1	3	4
763	Pneumonia of new-born	—	1	1
774	Immaturity with mention of any other subsidiary condition	—	1	1
776	Immaturity unqualified	2	1	3
		4	7	11

Causes of Infant Deaths—From One month to One year

		M	F	Total
353	Epilepsy	1	—	1
491	Bronchopneumonia	1	—	1
571	Gastro-enteritis and colitis except ulcerative, aged four weeks and over	1	—	1
762	Post natal asphyxia and atelectasis	—	1	1
763	Pneumonia of newborn	1	—	1
		4	1	5

APPENDIX IV

VITAL STATISTICS—COMPARISON, GUERNSEY/UNITED KINGDOM

		1963		1964		1965	
		England and Wales	Guernsey	England and Wales	Guernsey	England and Wales	Guernsey
Infant Mortality Rate		21.1	28.5	19.9	21.3	19.0*	19.61
Neo-Natal Death Rate		14.2		13.8		13.0	
		24.9		15.7		13.48	
Maternal Mortality		.28		.25		.25	
		—		1.1		—	
Tuberculosis (Respiratory)		.06*		.05*		.042*	
		.12		.04		.065	
Cancer All Forms		2.2*		2.2*		2.22*	
		2.2		2.2		2.27	
Cancer of Lung		.5		.5*		.55*	
		.6		.4		.48	

* Provisional Figures.

APPENDIX V

PUBLIC HEALTH DEPARTMENT

Cost of Operation

LABORATORY

Analysis	...	...	...	...	...	...	...	...	£529	3	10
Cleaning and Sundries	...	...	...	...	...	...	...	...	416	13	8
Medical Supplies and Equipment	...	...	...	...	...	...	...	...	1,227	3	2
									<hr/>		
									£2,173	0	8
									<hr/>		

63

PUBLIC HEALTH

Cleaning, Fuel, Light and Water	...	...	...	...	...	...	...	...	£541	6	0
Infectious Diseases—											
Doctors' Fees	...	...	...	...	...	...	...	...	£156	11	0
Drugs, Vaccines, etc.	...	...	...	...	...	...	...	...	997	13	11
									<hr/>		
									1,695	10	11
Postages, Stationery and Telephone	...	...	...	...	...	...	...	...	603	13	11
Salaries and Wages	...	...	...	...	...	...	...	...	25,557	16	3
Superannuation	...	...	...	...	...	...	...	...	3,208	2	0
Travelling Expenses	...	...	...	...	...	...	...	...	1,442	2	6
V.D. Clinic	...	...	...	...	...	...	...	...	495	8	6
Other Expenses	...	...	...	...	...	...	...	...	1,910	17	0
									<hr/>		
									£34,913	11	1
Less: Recoveries from Education Council	...	...	...	...	...	...	...	...	4,500	0	0
									<hr/>		
									£30,413	11	1
									<hr/>		

APPENDIX VI

SCHOOL MEDICAL SERVICES

ANNUAL REPORT FOR 1965

During the year the School Medical Services have been augmented by the addition of a special clinic for conditions of the Ear, Nose and Throat, conducted quarterly by Mr. G. Midgley M.R.C.S., L.R.C.P., D.L.O. In September, the Speech Therapy Clinic was able to re-open as a result of the appointment of Miss J. M. Richmond L.C.S.T. This opportunity is also taken to welcome another School Nurse/Health Visitor to the staff at Lukis House, Miss M. Thomson Brown, who took up her duties in February, 1965.

The services have operated smoothly throughout the year. Thanks to the help of Dr. Elizabeth H. Witherick M.B., B.Ch., a greater volume of work has been possible; indeed without her appointment on a sessional basis commencing in the Summer Term, it would not have been possible to complete the year's programme of work. Dr. Witherick's return to the School Medical Services has been most welcome and thanks are due to the Education Council for their agreement to her part-time appointment.

Altogether 1,725 school children underwent routine medical inspections either at their school or by arrangement at Lukis House. In addition 369 children were referred to the School Medical Officer's clinics, making a total of 2,122 medical examinations.

Total number of school children examined during 1965 at routine medical examination at school and at Lukis House:

Table A

		2,122	
		<hr/>	
Total number examined at schools	... ..	1,503	} 1,753
Total number examined at Lukis House for routine medical examinations	... ..	250	
(including 55 examinations carried out at clinics).			
Total number of children seen at Lukis House clinics	... ..	369	
(excluding 55 routine examinations).			
		<hr/>	
		2,122	
		<hr/>	

Table B 1. Children examined at school (1,503)

	Boys	Girls	Total
Infants	421	410	831
Juniors	288	254	542
Seniors	63	67	130
	<hr/>	<hr/>	<hr/>
Children	772	731	1,503
	<hr/>	<hr/>	<hr/>

Table B 2. Children examined at Lukis House (250)

					Boys	Girls	Total
Infants	...	...	...	...	27	25	52
Juniors	...	...	...	...	0	0	0
Seniors	...	...	...	...	72	71	143
At Clinics	...	...	...	...	29	26	55
Children	...	...	...	...	128	122	250

Total routine medical inspections = 1,503 + 250 = 1,753.

In Tables C 1, C 2 and C 3 are recorded some of the defects noted at routine medical inspections.

Table C 1. DEFECTS NOTED—INFANTS

					Boys	Girls	Total
Teeth	...	...	...	...	115	93	208
Skin	...	...	...	...	31	23	54
Eyes	...	...	...	...	42	36	78
E.N.T.	...	...	...	...	47	55	102
Speech	...	...	...	...	20	7	27
Heart	...	...	...	...	13	3	16
Asthma	...	...	...	...	17	13	30
Orthopaedic	...	...	...	...	2	2	4
Flat Feet	...	...	...	...	72	71	143
					359	303	662

65

Table C 2. DEFECTS NOTED—JUNIORS

					Boys	Girls	Total
Teeth	...	...	...	...	58	47	105
Skin	...	...	...	...	13	7	20
Eyes	...	...	...	...	41	34	75
E.N.T.	...	...	...	...	27	10	37
Speech	...	...	...	...	—	—	—
Heart	...	...	...	...	2	3	5
Lungs	...	...	...	...	9	1	10
Orthopaedic	...	...	...	...	3	1	4
Flat Feet	...	...	...	...	55	35	90
					208	138	346

Table C 3. DEFECTS NOTED—SENIORS

					Boys	Girls	Total
Teeth	...	...	...	...	31	24	55
Skin	...	...	...	...	3	3	6
Eyes	...	...	...	...	37	43	80
E.N.T.	...	...	...	...	6	4	10
Speech	...	...	...	...	1	—	1
Heart	...	...	...	...	—	1	1
Asthma	...	...	...	...	6	3	9
Orthopaedic	...	...	...	...	4	7	11
Flat Feet	...	...	...	...	38	24	62
					126	109	235

The development of defective eyesight

There are some interesting observations to be made among these tables, particularly if percentage rates are compared. It would appear that the incidence of defective eyesight is remarkably constant. For example:—Infants 78 cases; Juniors 75; Seniors 80. However, it is more interesting to compare the percentage rates. These are: Infants 8.8%; Juniors 13.8%; Seniors 29.3%. From a later table (Table E) it can be seen that the Orthoptist referred 65 cases for specialist opinion from her examination of infants in their first term at school. Altogether 714 infants were examined, giving a rate of 9.1%. In other words, almost one child in 10 has some defect of the eyes requiring specialist opinion at first school entry. A year later, when they attend for their first full medical inspection, almost the same number (8.8%) are either wearing spectacles or attending regularly for orthoptic treatment. Four years later, a further five per cent (13.8%) require specialist treatment. In a further four or five years, just before leaving school, this rate has more than doubled and nearly one child in three (29.3%) has required specialist attention through the School Medical Services.

Dental decay

The School Medical Officer's observations on defective teeth are not so useful a record as those made by the School Dentists. The School Medical Officer only comments upon gross evidence of dental caries. However, from a breakdown of figures provided by the Principal School Dental Officer (to whom grateful acknowledgement is here made) the following facts emerge. Of all infants examined by the School Dentists in 1965, no less than 45.2% required treatment. This rate rises to 61.3% of all juniors examined and falls slightly to 47.2% among school leavers. Of school children examined of all ages, it will be seen from the Principal School Dental Officer's report that almost exactly half required treatment in 1965.

This reflects a state of dental health among the school population which gives no grounds for complacency. These figures are very similar to those which, when recorded elsewhere, have led to careful consideration of the benefit to be gained from the fluoridation of drinking water supplies. In an increasing

number of instances the decision has been made to restore to drinking water known to be deficient in fluorides a quantity sufficient to ensure that the optimum concentration necessary to minimise dental caries is maintained. In Guernsey the fluoride concentration occurring naturally is 0.004 to 0.03 or only 3% of the optimum at best. The high level of dental decay among Guernsey school-children should therefore occasion no surprise, but must provoke a careful examination of the case for the fluoridation of Guernsey water supplies.

Dental health cannot be considered as a thing apart from general physical well being. Decaying teeth, even if they give rise to no pain, are responsible for a state of health below the optimum and can be the cause of systemic disease. When means are available for preventing much dental decay at less cost than the expense of treatment, there would seem to be little justification for ignoring them. It is a pity that by the very nature of things, wherever the decision has to be made, it must be made by those too old to benefit, while the penalty for withholding fluoridation must be borne by those too young to decide.

School Medical Officer's clinics

The School Medical Services clinics at Lukis House continue to perform a useful function, an average of eight cases each week, in term and out, being referred for one reason or another. Table D gives a classification of the cases referred during 1965.

School Medical Services clinics

Table D

<i>Categories referred</i>						
Teeth	...	...	...	...	...	4
Skin	...	...	...	...	...	2
Eyes	...	...	...	...	...	149
E.N.T.	...	...	...	...	...	51
Speech	...	...	...	...	...	36
Heart	...	...	...	...	...	2
Lungs	...	...	...	...	...	3
Orthopaedic	...	...	...	...	...	1
Asthma	...	...	...	...	...	1
Breathing exercises	...	...	...	...	...	5
Flat Feet	...	...	...	...	...	12
Extra Nourishment	...	...	...	...	...	5
Behaviour problems	...	...	...	...	...	14
Training College Candidates	...	...	...	...	...	39
Medical Inspections	...	...	...	...	...	55
						379

Orthoptics

The work of the Education Department's Orthoptist Mrs. Mary Edwards D.B.O. is summarised at Table E. The total of 2,215 attendances at the orthoptic clinic represents a very considerable amount of most valuable work. That this clinic is still expanding can be seen from the fact that 95 new cases were referred, as compared with 70 cases discharged during the year.

Table E. Cases of Visual defect referred for Specialist Opinion

(a) By School Medical Officer from school examinations ...	50	}	202
(b) By School Medical Officer from Lukis House clinics ...	87		
(c) By Orthoptist from school examination	65		
(d) New cases to Orthoptic Clinic	95		
(e) Total attendances at Orthoptic Clinic	2,215		
(f) Discharged from Orthoptic Clinic			
(53 as cured, 17 cosmetically satisfactory)	70		
(g) Squint operations performed by Dr. Neubert	25		

Child Guidance Clinic

The Child Guidance Clinic remains in the capable hands of Dr. B. J. Salisbury, M.B., B.S., D.P.M., D.C.H. to whom 26 new cases were referred in 1965. Altogether, 187 clinic sessions were held during the year.

Speech Therapy

For much of 1965 the School Medical Services were without a speech therapist. However, it is a pleasure to welcome Miss J. M. Richmond, L.C.S.T. who took up this appointment at the beginning of the autumn term. She was faced with a most difficult task, which necessitated a review of all the cases referred for speech therapy during the preceding nine months, as well as all the old cases who had been attending the clinic in 1964. She is to be warmly congratulated upon the way she has tackled and overcome this daunting task. Thanks to her efforts entirely, the speech therapy clinic is now running smoothly again and at the end of the year there were only five cases left on the waiting list—all recently referred. Only a suggestion of the work which this entails is conveyed by the following figures, taken from her annual report to the School Medical Officer.

Table F 1.

Annual Numbers

No. of children under treatment and/or observation	110
No. of children referred	37
No. of children admitted	44
No. of children for whom Speech Therapy was not indicated ...	7
No. of children who failed to attend for interview	1
No. of children discharged after treatment	22
No. of attendances	425
No. of interviews with parents or guardians	76

Table F 2.

Reasons for discharge

Speech within the bounds of normality	14
Speech very much improved	6
Failed to attend	1
Patient now attending U.K. special school	1
	—
Total	22
	—

Table F 3.

<i>Classification of defects</i>									
Alalia (absence of articulation and language)	...	...	...	...	...	...	...	...	6
Dyslalia (slow development of articulation)	...	...	...	...	...	...	...	...	54
Dyslalia with retarded language development	...	...	...	...	...	...	...	...	17
Dyslalia with deficient intelligence	...	...	...	...	...	...	...	...	8
Dyslalia (Dyslalia due to hearing loss)	...	...	...	...	...	...	...	...	5
Dyslalia with stammering	...	...	...	...	...	...	...	...	2
Stammering	...	...	...	...	...	...	...	...	6
Nonfluency	...	...	...	...	...	...	...	...	1
Dysarthria (defective speech due to neurological impairment)	...	...	...	...	...	...	...	...	2
Articulatory defect due to structural abnormality	...	...	...	...	...	...	...	...	1
Undiagnosed yet	...	...	...	...	...	...	...	...	8
Total									110

Table F 4.

<i>Autumn Numbers</i>									
No. of children under regular treatment	...	...	...	...	...	...	...	...	37
No. of children under observation	...	...	...	...	...	...	...	...	73
No. of children referred	...	...	...	...	...	...	...	...	31
No. of children admitted	...	...	...	...	...	...	...	...	37
No. of children for whom Speech Therapy was not indicated	...	...	...	...	...	...	...	...	7
No. of children who failed to attend for interview	...	...	...	...	...	...	...	...	1
No. of children discharged after treatment	...	...	...	...	...	...	...	...	22
No. of children on the waiting list at 21st December, 1965	...	...	...	...	...	...	...	...	5
No. of attendances	...	...	...	...	...	...	...	...	325
No. of interviews with parents or guardians	...	...	...	...	...	...	...	...	76

The Ear, Nose and Throat Clinic

In 1965 a new clinic was established as a part of the school Medical Services; the specialist Ear, Nose and Throat clinic, conducted quarterly by Mr. Gordon Midgley M.R.C.S., L.R.C.P., D.L.O. Mr. Midgley is no stranger to Guernsey; nevertheless this opportunity is taken to welcome him and his valuable services to schoolchildren. Three clinics were held in April, July and October and a total of 25 children seen. In each case, appointments for these clinics are made at the request, or with the consent of the family doctor concerned.

Table G

E.N.T.	Boys	Girls	Total
New cases	11	10	21
Reviews	2	2	4
Total	13	12	25

Tuberculin Testing and B.C.G. Vaccination

This programme has continued throughout 1965 and it is gratifying to observe that the acceptance rate for B.C.G. vaccination has risen to 97.8% of those children eligible to receive it. Only 27 parents refused to allow their children to receive B.C.G. and thus the number of unprotected children is but a small proportion of the whole. While no pressure is used to persuade parents to change their minds, it is perhaps appropriate to mention here that tuberculosis remains as great a risk to the adolescent as ever it did. There is a tendency to think of tuberculosis as a disease which does not matter any more, because doctors can cure it. No practising doctor would subscribe to this view and prevention remains the most potent weapon available for the control of this still deadly disease.

Table H 1. INFANTS

Total Infants examined ...	...	...	...	...	...	...	882
Known to be tuberculin positive	...	...	...	...	...	22	
Eligible for M.P.T.	...	...	...	...	...	...	860
Absent for M.P.T.	...	...	...	...	...	5	
M.P.T. refused by parents	...	...	...	...	...	23	28
M.P.T. performed	...	...	...	...	...	...	832 = 96.7%
Found to be tuberculin positive	...	...	...	...	...	9	
Found to be tuberculin negative	...	...	...	...	...	...	823

Table H 2. JUNIORS

Total of Juniors examined	...	...	...	...	...	521
Known to be tuberculin positive	...	...	...	...	21	
Absent for M.P.T.	...	...	...	...	3	
M.P.T. refused by parents	...	...	...	...	25	
					—	
					49	
					—	
M.P.T. performed	...	...	...	...	...	472
Found to be tuberculin positive	...	...	...	...	9	
Eligible for B.C.G.	...	...	...	...	...	463
Absent for B.C.G.	...	...	...	...	8	
B.C.G. refused by parents	...	...	...	...	2	
					—	
					10	
					—	
Number of Juniors protected by B.C.G. vaccination						453 = 97.8%

In addition 31 children received M.P.T. at clinics

27 children received B.C.G. at clinics

Head infestation

In my report for 1964, I forecast a substantial improvement in the tiresome matter of children having to be excluded from school because of infestation with head-lice. This has been fulfilled, as the tables below demonstrate.

1965

(a) Number of inspections	19,633	
(b) Children found infested	264	$\frac{(b \times 100)}{a} = 1.34\%$
(c) Children excluded from school	57	$\frac{(c \times 100)}{b} = 21.6\%$

And a comparison with five years ago:—

1960

(a) Number of inspections	10,434	
(b) Children found infested	653	$\frac{(b \times 100)}{a} = 6.26\%$
(c) Children excluded from school	557	$\frac{(c \times 100)}{b} = 85.0\%$

The year 1960 has been chosen because of the convenient intervening period of five years. It was by no means the worst year for which records could have been chosen. The new routine technique has, in fact, reduced to one tenth the number of exclusions in the space of five years, thus saving a very considerable amount of needlessly lost school attendance. It can be claimed that this particular affliction is now under control and it is to be hoped that further improvement may yet be achieved.

SCHOOL DENTAL SERVICE REPORT 1965

INSPECTIONS

During the year, the following schools were inspected.

St. Martin's Infants	Valnord
Notre Dame	Hautes Capelles Infants
St. Martin's Junior	Hautes Capelles Junior
Les Beaucamps	Ker Maria
St. Andrew's	Delancey
St. Joseph's	La Chaumiere
St. Peter's	Vale Infants'
Boys' Grammar	Vale Junior

This made up a total of 3,330 children inspected at school added to which were 319 children who, through absence at school inspection, were later seen at the clinic. Of those inspected at school, 1,634 required treatment, or 49.06%. This is an improvement of 2.24% on last year. Whilst this improvement is encouraging, it is still an appalling fact that one out of every two children have teeth needing extraction or filling. As we are unable to inspect any of our schools at intervals under fifteen months, this state of affairs must persist unless we use the most effective weapon known to man to combat decay, i.e. Fluoridation of the water supply. This well-tried, safe and inexpensive Public Health measure, will cut tooth decay by 60% in the younger children, and 40% in the older children. With this kind of reduction we could get on top of the problem.

TREATMENT

Conservative

Children, especially those in the older groups, are becoming more filling conscious. With the older children, however, the cavities are of a compound nature as distinct from the simple, one-surface filling of the seven year old. Many more compound fillings were completed in 1965, this trend being a very favourable one, in so much as more school leavers are dentally fit, and have been dentally educated.

EXTRACTIONS

Both permanent and deciduous extractions are down, the former by 167 and the latter by 954. This shows a greater awareness and desire on the part of parents and children to have teeth conserved rather than extracted.

GENERAL ANAESTHETICS

The amount of General Anaesthetics administered decreased. Many more deciduous teeth were extracted by Local Anaesthetic than in previous years.

ORTHODONTIC AND PROSTHETIC

Although the number of appliances and plates increased to 73, our work in this field remains largely preventative, viz, the extraction of premolar teeth to allow the canine teeth to erupt and come down and back.

X-RAYS

The Phillips Oralix X-Ray apparatus continues to be a great help in diagnostic and Orthodontic work.

EQUIPMENT

The installation in August of warm air syringes in both surgeries and an air turbine in the lower surgery, has been a great help and facilitates the carrying out of conservative treatment.

FIGURES FOR 1965

Extractions

Permanent teeth	...	...	...	...	...	...	...	740
Temporary teeth	...	...	...	...	...	...	...	1,922

Fillings

Permanent teeth	...	...	...	...	...	...	...	4,107
Temporary teeth	...	...	...	...	...	...	...	652
Scalings	...	...	...	...	...	...	...	344
Gum treatments	...	...	...	...	...	...	...	67
General Anaesthetics	...	...	...	...	...	...	...	1,058
Orthodontic and Prosthetic	...	...	...	...	...	...	...	73
Treatment completed	...	...	...	...	...	...	...	2,352

